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IMPLEMENTATION OF ELIGIBILITY REFORMS UNDER PUBLIC LAW 99–272, THE STATUS OF RECRUITMENT AND RETENTION OF VA HEALTH CARE PERSONNEL, AND H.R. 1659

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

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IMPLEMENTATION OF ELIGIBILITY REFORMS UNDER PUBLIC LAW 99-272, THE STATUS OF RECRUITMENT AND RETENTION OF VA HEALTH CARE PERSONNEL, AND H.R. 1659

Wednesday, April 22, 1987

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice at 9 a.m., in room 334 Cannon House Office Building, the Honorable G.V. (Sonny) Montgomery (chairman of the subcommittee) presiding.

Present: Representatives Montgomery, Hammerschmidt, Solomon, Penny, Staggers, McEwen, Rowland of Georgia, Smith of New Jersey, Bryant, Rowland of Connecticut, Robinson and Kennedy.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

Mr. MONTGOMERY. The subcommittee will come to order. Today there are three subjects pertaining to our hearing. Two are central to the mission of the VA's Department of Medicine and Surgery, and the third is a very important component of the ability of the VA to deliver extended care.

It is nice to see the ranking minority member here today, Mr. Solomon. Mr. Hammerschmidt. Glad to have you back from the Soviet Union. Tim Penny, glad to see you. Dr. Roy Rowland, back from the Philippines.

The first topic is the implementation of the eligibility reforms under Public Law 99-272.

That legislation redefined veterans' eligibility for VA medical care. Every veteran who was previously eligible for VA medical care is still eligible.

However, Public Law 99-272 made a requirement that hospital care be provided to a group of veterans that has come to be termed "Category A."

Today, we would like to find out about the implementation of the eligibility reforms and the results to date.

The second topic is a recruitment and retention of health care personnel in the VA. All of us on the committee have been very concerned to hear of shortages of health care personnel in the VA.

Early this year, the committee conducted a survey of the personnel situation in VA medical facilities. 150 medical centers responded to the survey. Overall, nursing vacancies averaged 55 calendar

days. Pharmacist vacancies averaged 102 calendar days. Respiratory therapist vacancies averaged 47 days, physical therapist vacancies averaged 276 days, licensed practical nurse vacancies averaged 57 days.

Now, these kinds of vacancies can only have a negative effect on the VA's ability to deliver medical care. We would like to find what the VA has done to address these problems.

The third topic is a bill, H.R. 1659, that would increase per diem reimbursements paid to State veterans homes for the care of veterans. In addition, the bill would clarify the authority of the VA to award grants for State veterans homes during the fourth quarter of fiscal year 1987.

The State Nursing Homes Program is a century-long partnership between States and the VA and has really been cost-effective and has been very beneficial.

The last time the per diem rates were raised was 3 years ago. The proposed increase would bring the VA portion of the total daily cost of operating State veterans nursing homes to 25 percent.

At the conclusion of the hearing, we will mark up H.R. 1659.

At this time, without objection, I would like to submit my full written statement for the record.

[The prepared statement of Chairman Montgomery appears at p. 45.]

Mr. MONTGOMERY. There is a large number of witnesses who have taken the time to come before us today and I want to give them as much time as possible, but if they can get to the points, this would help us to mark up this legislation.

I would like to recognize the ranking minority member of the subcommittee for any remarks he might like to make, John Paul Hammerschmidt.

OPENING STATEMENT OF HON. JOHN PAUL HAMMERSCHMIDT

Mr. HAMMERSCHMIDT. Thank you, very much, Mr. Chairman. I am pleased that we are taking the time today to review Public Law 99-272, the veterans eligibility reforms. Legislation, as we know, made a fundamental change in how eligibility is determined for veterans' health care benefits.

For the first time, the Congress clearly provided for the veterans who most need health care, service-connected disabled veterans and poor veterans. And as we review this Act, it is important to keep in mind that the original purpose of this legislation was to provide better and more cost-effective health care to our Nation's veterans.

Public Law 99-272 was never intended to be use, and the Congress will never tolerate it being used as a tool to limit or reduce the level of care provided to our veterans.

The management of the VA programs should be left to the VA, but the VA and OMB must understand that Congress will not sit idly by as attempts are made to restrict benefits to veterans who are entitled to receive them.

Mr. Chairman, of all the issues facing our subcommittee this year, few are as important to the care of our veterans population

as the retention and recruitment of qualified health care personnel.

The Veterans Administration with the support of Congress should aggressively address this growing crisis. We must begin by making salaries more competitive with those in the private sector.

The VA is simply not going to attract and retain health care professionals, especially nurses and pharmacists, unless salaries are more competitive. In those areas of the country where this is difficult, the VA may well have to provide more flexible working schedules, child care and tuition reimbursements. In effect, the entire compensation package will have to be as attractive as those offered by the private sector with which the VA must compete for qualified professionals.

Finally, Mr. Chairman, I am also pleased that we will be marking up H.R. 1659 later today, which I cosponsored. As I said before, our veterans population is, on the average, aging more rapidly than the general population, and as this segment of the population matures, State veterans homes will play an increasingly important role in providing quality medical care to our Nation's veterans.

There has not been a per diem increase since 1984, and reimbursement rates must be adequate to encourage continued participation by State homes.

Thank you, Mr. Chairman.

[The prepared statement of Congressman Hammerschmidt appears at p. 50.]

Mr. MONTGOMERY. Thank you. Mr. Penny.

OPENING STATEMENT OF HON. TIMOTHY J. PENNY

Mr. PENNY. Thank you, Mr. Chairman. The Members of this subcommittee are well aware of the effectiveness of the State Veterans Home Program, which today provides extended care in State homes, hospitals and domiciliaries for well over 20,000 veterans.

I am certain that the testimony presented this morning will again point out the fine job of delivery of long-term care services provided by our State veterans homes, hospitals and domiciliaries and will support sustaining the State Home Program.

As recommended by the full committee in its report to the House Budget Committee, I have introduced legislation, H.R. 1659, that would increase the per diem reimbursement rate to State veterans facilities. The bill also contains a provision that allows the awarding of State home construction grants to continue, as we had intended, during the last quarter of fiscal year 1987.

I appreciate your support for this legislation, Mr. Chairman, as well as the support of Mr. Hammerschmidt, Mr. Solomon and others of this committee. I look forward to hearing the testimony today on this issue and at the appropriate time, will ask for favorable action of this subcommittee on the bill.

Mr. MONTGOMERY. I might say that I have visited in your State, and the nursing home program out there is one of the best in the country.

Mr. Solomon.

Mr. SOLOMON. Mr. Chairman, I don't have a statement, but I wanted to stop by to thank Mr. Penny, you and the other sponsors

of this legislation, which I am proud to be a sponsor of, too, for bringing it to this subcommittee in a timely manner. We appreciate it very much, and I do wholeheartedly support the bill and I hope you can report it out favorably, and let's get it on to the House.

I understand, Mr. Chairman, you had a very successful trip to the Philippines and look forward to discussing that with you and the other members who were on the trip with you.

Mr. MONTGOMERY. Thank you. We certainly think there is a need for stopping the destruction of Corregidor, where much of our history of World War II is involved. We hope that we can take a reasonable approach to save Corregidor. We received the assurance of the Philippine Government that they would put security on the island.

That is one of the problems; the great 12-inch guns are being destroyed; piers are being destroyed, roads and then the memorial, which we have over $2 million invested in is just falling apart. It would be like Iwo Jima in Arlington Cemetery being destroyed in front of our own eyes. We have to do something about it.

Also, Mr. Solomon, I went before the Rules Committee pertaining to the supplemental—I only mention this for our audience because we have some veterans' organization represented. We requested that you and I be permitted to offer an amendment that would transfer $20 million from the $425 to take care of the homeless in this supplemental appropriation, to be put in the VA Budget where when the Veterans Administration can open domiciliary beds that they do not have right now—as the homeless pointed out, we can provide for homeless veterans in our urban hospitals.

We feel like we could do a better job bringing them under our jurisdiction.

I think that amendment will be made in order and I will, with you, offer it whenever we get to the supplemental.

Dr. Rowland.

Mr. ROWLAND OF GEORGIA. Thank you, Mr. Chairman. With reference to our trip to the Philippines, I want to commend you for moving expeditiously since we got back, in talking to the Navy, and talking to the Secretary of State to do something about the deteriorating condition of the memorials that are on Corregidor. I commend you for doing that.

I also want to welcome all of the witnesses here this morning, who have agreed to come. I know that they have taken some valuable time away from their own pursuits, and we really appreciate their coming.

Mr. Chairman, I don't think there is any more important issue in medical care than that of personnel. The technology that we are so fortunate to have now depends on the high quality of personnel and staff to use it, and I am concerned when we hear about the shortages in the VA health care system now for personnel, and I hope that this morning we can find some solutions to ease that problem.

In my own home town of Dublin, Georgia, we have a VA facility there, as you know, and we have recently gotten two new physicians in that facility last year, fine physicians that I have known for a good while. I would like to know a little bit more about how

we got those physicians to come there, because there is a shortage of physicians in the VA.

The second topic that is going to be discussed this morning has to do with eligibility for VA medical care that was changed by Public Law 99-272. Passing that legislation was a tough job and it resulted in a significant change in eligibility and I was pleased to read in the written testimony for today that the implementation of that law seems to be going smoothly as this time.

It is always difficult to change rules and regulations, but the benefits to veterans and to the VA and to the Congress resulting from this law, I believe, far outweigh the efforts required to put it into effect.

The State Home Program is a good one and it is appropriate to make sure that the per diem and reimbursement is appropriate. I think that in my State of Georgia, the State veterans homes there are good ones; we participate in that program a great deal. It seems that this type of facility around the country would certainly be good for the veterans and the States and the Veterans Administration.

I look forward to hearing the oral testimony this morning, and the useful question and answer opportunity. Again, I want to thank all of the witnesses for their time, and thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you, Dr. Rowland. I also want to personally thank you for making the trip. We had to take some members over there or it would not be worthwhile going over to the Philippines. I hope our report will be out in the next few days, where it can be read and we can move ahead on trying to save Corregidor.

If Dr. John Gronvall will come forward, the chief medical director, Veterans Administration, and he can introduce the persons with him this morning.

Without objection, your full statement will be put in the record.

STATEMENT OF DR. JOHN A. GRONVALL, CHIEF MEDICAL DIRECTOR, VETERANS ADMINISTRATION; ACCOMPANIED BY: VERNICE FERGUSON, DEPUTY ASSISTANT CHIEF MEDICAL DIRECTOR FOR NURSING SERVICE; MICHAEL RUDD, DIRECTOR, OFFICE OF PERSONNEL AND LABOR RELATIONS; ROBERT E. LINDSEY, DIRECTOR FOR OPERATIONS; AND MICHAEL LAWSON, DIRECTOR, MEDICAL ADMINISTRATION SERVICE

Dr. GRONVALL. Thank you, Mr. Chairman. It is truly a pleasure for us to be here today to have this opportunity to review with the committee some very important aspects of our VA health care program.

Here at the table with me, from my left, are Mr. Michael Lawson, who is the Director of our Medical Administration Service; immediately to my left, Mr. Michael Rudd, who is the Director of our Office of Personnel and Labor Relations; immediately on my right, Ms. Vernice Ferguson, who is in charge of our Nursing Program for the entire VA; and to my far right, Mr. Robert Lindsey, who is the Director of Operations.

I will summarize the high points of my statement and I appreciate your agreement to print the full statement in the record.

It is very clear, Mr. Chairman, that our goal is to be competitive as an employer and that is, of course, crucial to our ability to deliver high quality care to veterans. We have been having problems, particularly in recent months, and so in order to ensure that we were taking both short and long-run steps to correct those problems, we did an intensive survey in December 1986 to determine the detailed status of recruitment and retention in 16 different health care occupations.

This survey did, in fact, document significant recruitment and retention problems for registered nurses, pharmacists and for physical and occupational therapists as many of our medical facilities. These problems were characterized by high turn over rates which added to the problems.

These problems, I think, basically come about because of competition for these quality health care personnel in the marketplace. Employers outside the Federal Government are responding to these recruitment problems by providing many new features in employment packages, including tuition assistance, continuing educational opportunities, day care for children, paid health and life insurance, recruitment bonuses and a long list of other factors.

We in the VA have taken both short-run and long-run steps to deal with this problem and improve our competitive position. In the short run, we significantly intensified our review and use of the special salary rate program. So that as of February we have some 356 special salary rate authorizations in place, providing special salary rates to some 9,700 employees.

These special rates provide from 7 to 19 percent salary above the normal salary levels for RNs; 5 to 19 percent above normal salary levels for pharmacists; and 4 to 21 percent above normal salary levels for physical therapists.

In addition to special rate action this year, we have recently identified $2.5 million which we will utilize during fiscal year 1987 for tuition assistance. This tuition assistance will be in addition to the funding for establishment of a scholarship program, again, in 1988. During 1988, we will expend $4.5 million for nursing scholarships and $1.0 million for scholarship awards for physical therapy students.

Our scholarship program in the past has been successful. Our experience shows that some 73 percent of the full-time nursing participants have stayed in the VA after scholarship support and their obligated service period, and to date, all of the part-time scholarship participants have stayed employed in the VA.

I mentioned that we are taking long-range steps. We have created a large agency and departmental task force to identify every possible step we could take which would, in the long run, improve and strengthen our recruitment and employment posture.

Our task force is hard at work reviewing such things as improvements in benefits packages, the recruitment budgets that we have, the possibility for expansion of our Saturday premium pay, the question of recruitment bonuses for new hires, and many other factors of that sort.

By early this summer, we will be having reports from that task force and we intend, with vigor, to pursue whatever package of actions and steps we can take which will provide long-term improvement in our recruitment posture.

Let me go on to make just very brief comments about the eligibility revision that was implemented in all of our medical centers on July 1, 1986.

The new eligibility statute, of course, established the three categories of eligibility—so-called Category A, B and C. My formal statement includes a detailed two-page summary of statistics that documents our total experience during the first five months of this current fiscal year 1987.

In brief summary, our experience has been that the Category A applicants, or veterans falling into Category A has been quite constant, at about 94 percent of all veterans coming to us for care; Category B is just under 3 percent, and Category C veterans applying for care are about 2.4 percent.

When we compare our experience this year with previous years, there is a slight reduction in the total number of applications that we have documented, but we really believe that this does not reflect a basic change in the number of veterans coming to us for care. Our new DHCP software, which we are using to document applications for care, we believe has eliminated some double-counting that occurred in the past, and we now believe we have more accurate documentation.

We will, of course, continue to very closely monitor our experience and will continue to make regular reports to the committee.

The final comment I would make, Mr. Chairman, has to do with the legislative proposal which would first increase per diem rates and then provide a mechanism for funding grants during the transition period.

We did submit a report to the Congress last fall, as required by law, documenting our assessment of the projection of per diem rates. That report documented factors which would suggest that the per diem rates are adequate. It documented other factors suggesting that an increase in rate in the coming years would be necessary.

The report concluded that, looking over the next 5 year period, some increase in per diem rates may be appropriate, but the VA at this time is not recommending an increase for the fiscal year 1988.

In regard to the so-called transition period, the revision in the eligibility and prioritization statute created a problem which the committee has recognized in that the Administrator now cannot make grants during that period.

We agree in concept that grants should be made during this period, but the proposal, as now written, creates an equity problem in that prior to passage of Public Law 99-567 we notified a number of States that we would have funds during fiscal year 1987 that would be available.

The proposal, as now written, would shorten by three months the time available to the States to complete their grant applications and receive a grant.

So we recently transmitted to the Speaker of the House a draft bill that would give those States until October 1, 1987, to meet the

requirements for receiving a VA grant, and we recommend that the committee adopt this modification to H.R. 1659.

Mr. Chairman, that concludes my summary opening comments. My colleagues and I, of course, will be pleased to answer questions. Thank you, very much.

[The prepared statement of Dr. Gronvall appears at p. 52.]

Mr. MONTGOMERY. Thank you. Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman, and thank you, Dr. Gronvall, for your statement.

Dr. Gronvall, the current recruitment and retention problems could deprive our veterans of adequate medical care. In my view, Congress would support requests for additional resources to address this problem.

My question to you is: Is the VA really taking this crisis seriously and attempting to bring the entire compensation package for health care professionals up to par with those in the private sector?

Dr. GRONVALL. I believe, sir, that we are taking it extremely seriously. There are regular discussions, regular attention paid to the matter. Our survey was an elaborate one, produced a great deal of data and as I commented in my opening statement, my intent is to ensure that we look at every possible mechanism, both short run and long run, to ensure that we are in a competitive position.

Mr. HAMMERSCHMIDT. In what areas of the country is the recruitment and retention problem the most serious, and what specific steps has the VA taken in these particular areas?

Dr. GRONVALL. The problem, as your question suggests, is quite different in various geographic areas of the country. We have tailored, particularly our special rate approval, to those areas of the country where we have the most severe problems.

I think Mr. Lindsey could summarize for us the parts of the country that are having the most serious problems.

Mr. HAMMERSCHMIDT. Mr. Lindsey, would you do that for us, please?

Mr. LINDSEY. In looking at the special rate requests, we have dealt with, the areas with the most severe problems have been in the Northeast, in the Boston and New York areas, and on the West Coast.

Mr. HAMMERSCHMIDT. One of the witnesses testifying today, in the testimony as we have gone through it, estimates that the VA currently faces a nursing shortage of between 4,000–8,000. What will be the effect of this if this situation worsens, Dr. Gronvall?

Dr. GRONVALL. Clearly, if the situation worsened and we had further significant or major reductions in our nursing staff, that would have a very negative impact on our ability to deliver care to veterans. We would take appropriate steps to ensure that the quality of care that we give is excellent, but a major further reduction would, I think, necessitate a reduction in the amount of quality care that we could deliver.

Mr. HAMMERSCHMIDT. On page 2 of your statement you mention that almost $2 million in uncollected co-payments exists. What is being done to try to collect these debts?

Dr. GRONVALL. We, of course, follow very specific rules in billing and then attempting to collect all debts owed to the Federal Gov-

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ernment. Those uncollected funds, I should add, are not eroding our financial position in regard to salary support because the collected funds are deposited directly in the Treasury, rather than becoming part of the budgets of the individual medical centers.

Mr. HAMMERSCHMIDT. How successful is that effort?

Dr. GRONVALL. I think it is too early to tell how successful the collection of co-payments and the collection of third-party reimbursements is going to be. That legislation is new and we are only beginning to have enough experience to know whether it is going to be successful.

I don't think I can really answer that at the present time.

Mr. HAMMERSCHMIDT. I guess that is something this committee will have to track in its oversight responsibilities. It may be too early to ask for you to give us any statistics, but at some point down the road, I do think we need to keep close communication on that item.

Dr. GRONVALL. Yes, sir. I absolutely agree.

Mr. HAMMERSCHMIDT. You mention in your testimony that to remain competitive additional benefits, such as tuition assistance, day care and other benefits are necessary to recruit and retain medical professionals.

Do you believe the level of resources the VA allocates for these purposes is adequate to address this problem?

Dr. GRONVALL. The kinds of items that you refer to were described in our statement as being used by employers with which the VA has to compete. A number of those items are not currently being done by the VA. The principal purpose of the task force that we established a couple of months ago was to look at those and any other items with the intent that we will put together a package of steps that we believe will be necessary to deal with the competition and make program recommendations on that basis.

Mr. HAMMERSCHMIDT. Do you think the VA is ahead of the curve on this problem?

Dr. GRONVALL. No, I believe that we are not ahead of the curve. That is primarily, I think, because individual hospitals in an individual community have the local flexibility to adopt such measures in quite short order. The establishment of new recruitment mechanisms or retention mechanisms in the VA, particularly if they require legislation or recognition in the budget—requires a long process of review and development before we can put a similar effort in place.

Mr. HAMMERSCHMIDT. I see my time is up. Thank you, very much, Dr. Gronvall, and thank you for your responses.

Mr. MONTGOMERY. Thank you, Mr. Hammerschmidt. Mr. Penny.

Mr. PENNY. Thank you, Mr. Chairman. I have several questions and I hope we can get through them in the time we have.

I am curious to sort out which study done by the VA is the accurate study. The VA study of the demand for care completed last year revealed that approximately 35,000 veterans are being turned away monthly, mostly for out-patient care.

The Report on Public Law 99-272 shows no one being turned away. Which report would you say is the accurate report?

Dr. GRONVALL. The two reports and the two compilations of information were done at different times, one prior and the other

after the revision in eligibility. The first report that you referred to, demand for care, was a short-term sample that had been done several times. It was done using a different set of assumptions, a different set of descriptions and making that extension to monthly data.

The information that we submitted with our statement has been collected since last July 1, and represents comprehensive documentation of every applicant who has come to our medical center to seek care.

So I believe that the data that are now before you represents to the best of our ability to portray it, an accurate and total documentation of every veteran who seeks care and what has happened to that veteran.

In fact, in the five months' experience that we documented, some 734 veterans did not receive care because the particular treatment modality necessary was not available.

Mr. PENNY. Say that again.

Dr. GRONVALL. 734 veterans who sought care were not provided care because the particular treatment modality was not available at the medical center at which they sought care.

Mr. PENNY. Would those be Category A veterans?

Dr. GRONVALL. There are a few Category A veterans for whom that was true; the preponderance of those are Category B and C veterans.

Mr. PENNY. How do you handle Category A veterans if they cannot get the required care at the facility that they visit?

Dr. GRONVALL. Again, it depends on the care that is necessary. In the individual instance where the given medical center can't provide the care, our social work service seeks a way to transfer the veteran to another VA medical center or to another DOD facility with which we have a sharing agreement.

If the veteran needs hospital care, we have clear authority to provide that by hospitalizing the veteran in a private facility and paying for the care.

Mr. PENNY. I really think that for those veterans in particular, you really have to make that extensive effort to assure that care is available.

Dr. GRONVALL. I believe, Mr. Penny, that we have made an extremely serious effort to ensure that every Category A veteran does receive the care that is needed. I think the record of what has been accomplished for the over one million veterans that have come to us for care is a record of success in ensuring that all Category A veterans get care.

Mr. PENNY. I want to move on to the nursing home per diem issue. Your new policy emphasizes the use of State veterans nursing homes to meet the need for care. I guess I am having trouble with an objection to this legislation which seems to me an encouragement for States to offer to provide care, given the fact that it is really the most cost-effective way to deal with nursing home care for veterans.

Do you want to elaborate on the position of the VA on this bill and how that is consistent with your publicly stated policy of utilizing State nursing homes more extensively?

Dr. GRONVALL. I would be pleased to. You are quite right that for the past year and a half we have clearly stated a long-term strategy calling for increased reliance on State homes. Our budget sought and then has been funded at a significant increase for the State Grant Program.

I think the reasons for the conclusion that we came to in regard to the per diem rate in 1988 were really developed in some detail in the report we submitted last fall. We tried to project ahead for the next 5-year period, document all the factors that would lead to a conclusion that the rate should be increased, all the factors that weighed in the opposite direction, and this final conclusion I think was a part of prioritization process in view of all of the competing needs which finally, after all that review was over, led to an agency position that we do not, on balance, recommend a rate increase in 1988.

Mr. PENNY. Of course, if you received funding on the order of the levels recommended by the House budget resolution instead of the levels recommended by the Administration, then certainly, it would change the decision down at the VA as to your ability to handle this, or the priority that it would take.

It seems evident to me that you had to come up with a recommendation that somehow fit in with what the Administration is going to recommend in a budget for you and on that basis did not recommend an increase here.

Clearly, with the budget levels that we are recommending in the House Budget Committee, it is something we have made room for, and what I am getting at, it seems constantly here that the OMB forcing you to squeeze down in areas that you would otherwise place a higher priority on.

Dr. GRONVALL. I believe you are quite correct that the budget recommendations of the VA are consistent with and a part of the total Administration budget recommendation. So you are quite right, that when priorities are set on individual programs, it is in the context of the total request in the President's budget.

If the actual amount of funding made available for VA health care programs significantly exceeds that amount, then that changes many questions of prioritization among various competing program needs.

Mr. PENNY. Mr. Chairman, I have run out of time.

Mr. MONTGOMERY. The Chair will come back to the gentleman. Mr. Solomon.

Let the record show he was here.

Dr. Rowland.

Mr. ROWLAND OF GEORGIA. Thank you, very much, Mr. Chairman.

Dr. Gronvall, in your testimony you referred to localized recruitment and retention problems for these Title 38 personnel, professional personnel. This Salary Rate Program was intended to fit this situation. This committee received testimony that the cost of these special salary rates must be absorbed by the local VA facilities that request the rate.

If that is so, that would mean that money would have to be shifted from some other area to pay the additional personnel. Further, if that is true, is the VA requesting in its supplemental funds to

help meet those costs, and if you have not, why haven't you done so?

Dr. GRONVALL. Dr. Rowland, as we have moved through this year and reviewed the special rate requests, we have approved them based on their priority for recruitment. In each case, we have then looked at the degree of flexibility of funding available at the given medical center as well as whatever flexibility exists at the Washington level.

We have attempted to use the best individualized judgment about what the source of funds should be. Since these rate increases are being approved on an on-going basis throughout the entire year, the funds clearly come out of whatever the total appropriation is that is available to the VA.

You are correct that the supplemental appropriation request for 1987 that is before the Congress, submitted as a part of the 1988 President's request does not include a projection of the estimated amount of special salary authorizations that will be made during the remainder of the year.

Again, I think that reflects a prioritization judgment within the context of developing the President's budget as to whether the special salaries could or could not be absorbed within the appropriation request that was submitted.

Mr. ROWLAND OF GEORGIA. Do you think that the money having to come from the local budget of the VA facility might make their be some reluctance on the part of the Administrator to recruit personnel, if he is going to have to shift money from some other area?

Dr. GRONVALL. In not every case does all the money come from the local facility. I will ask Mr. Lindsey to comment on that.

I think that we hold the local medical center director and his or her staff accountable for quality care. We view them as being in the best position to balance those competing priorities of personnel numbers versus salary levels, and so we rely very heavily and I think appropriately on their judgment.

Mr. ROWLAND OF GEORGIA. May I say that if there is a bind there, and apparently there is in some areas, why wouldn't you request supplemental funds to help them relieve that situation?

Dr. GRONVALL. I think the answer is that it has to do with at least the total magnitude of the estimated amount of additional money that we may need.

At least our best judgment for the remainder of 1987 is that we will need some $25-$30-$35 million. That is an amount I think that is judged not appropriate to be considered in a supplemental request to the Congress, in view of other priorities in the Administration's budget.

Mr. ROWLAND OF GEORGIA. I am not sure it is altogether clear to me. Are you making this request for those funds for personnel?

Dr. GRONVALL. No, sir.

Mr. ROWLAND OF GEORGIA. All right. Let me ask you one other question concerning personnel. I understand, and you correct me if this is not true, that as a matter of courtesy, the Office of Personnel Management approves this additional personnel before you do even though the director may have the prerogative to do that.

Dr. GRONVALL. The local—if by that you mean the special rate approval?

Mr. ROWLAND OF GEORGIA. Yes, that is right.

Dr. GRONVALL. The local medical center director does not have authority to grant the special salary rates. Those requests, when they are Title 38 occupations, are reviewed by our personnel office in the Central VA, then come to the Department of Medicine and Surgery with those staff comments. They are reviewed within the Department on a priority basis. A recommendation is made and the chief medical director has approval authority for the rate increase.

Mr. ROWLAND OF GEORGIA. Then you do not go to the Office of Personnel Management. You can make that decision directly without going through OPM; is that correct?

Dr. GRONVALL. With regard to Title 38.

Mr. ROWLAND OF GEORGIA. That is what I am talking about.

Dr. GRONVALL. Yes, sir.

Mr. ROWLAND OF GEORGIA. All right. You bypass OPM. What about Title 5?

Dr. GRONVALL. For the Title 5 occupations, that requires, in addition to the steps I have just described, it requires a formal OPM review and approval before we can implement the rate increase.

Mr. ROWLAND OF GEORGIA. That is by law?

Dr. GRONVALL. Yes, sir.

Mr. ROWLAND OF GEORGIA. Would it be helpful to you if you could bypass OPM?

Dr. GRONVALL. I think that my understanding is that there are valid reasons why the Office of Personnel Management is involved on a government-wide basis in priority setting about special rate adjustments.

Mr. ROWLAND OF GEORGIA. Mr. Chairman, my time is up. I want to pursue this further when you come back.

Mr. MONTGOMERY. The Chair will recognize you. We will go around and come back to you.

Mr. Robinson.

Mr. ROBINSON. No questions.

Mr. MONTGOMERY. Mr. Bryant.

Mr. BRYANT. No questions.

Mr. MONTGOMERY. Another Mr. Rowland, from Connecticut.

Mr. ROWLAND OF CONNECTICUT. Thank you, Mr. Chairman.

The Gentleman from Georgia makes an excellent point. I would like to pursue it for a moment because I am not sure I am clear on the answer.

Dr. Rowland indicated that with the special rate consideration there could be a disincentive to the local director because of the question of whether it comes out of his own budget. I didn't quite understand.

Does that local VA hospital absorb that special rate cost, or is it at the discretion of the VA to determine when they will absorb that cost, or is it shared, or what is the clear answer?

Dr. GRONVALL. I believe the answer is all of the above.

Mr. ROWLAND OF CONNECTICUT. That is what I thought the answer was before, too.

Dr. GRONVALL. Let me ask Mr. Lindsey to clarify why.

Mr. LINDSEY. Because of the magnitude of the request for many of the medical centers, the procedure which we have established is

that there be medical center concurrence that the rate which is finally established will meet their needs from their perspective, and also we enter into a negotiation with the medical center in terms of what portion of the special rate authority can be absorbed by the medical center or must be supported by the region, or by Central Office, and there is also a concurrence at the medical center level on what their portion should be.

Then when that decision is finally resolved, then we make a funding action to support that.

Dr. GRONVALL. So, in summary, the judgment may be made that the individual medical center must absorb the entire cost.

Mr. ROWLAND OF CONNECTICUT. Let me pursue that. Mr. Lindsey, I was very pleased to hear you say that there are special needs in the Northeast and there is without a doubt—I represent Connecticut, and we have had tremendous competition for pharmacists and registered nurses, right on down the line, not only because of the economic boom and the competition for all jobs, but we are also close to other hospitals. So we have had some real problems, and we have gone back and forth at it numerous times.

I think you gave the answer, and the answer is it depends on the circumstances and each is treated separately. But indeed, the problem I think is that each and every year, that region, for example, the Northeast, is going to have to go back to the till each time as the turnover occurs for special rate designation.

Following up on Mr. Rowland's question, I think the concern becomes how does the local director balance whether he is going to go through the special rate issue each year, not knowing whether it is going to come out of his own budget or not, and doing the continuing balancing act.

I recognize your answer and I will accept that. What I would like to do is go a step further and perhaps to you, Doctor, with an area like the Northeast that goes through a special rate consideration on a continuing basis, what is the fall-out to the other personnel that have been there for 10, 12 or 15 years?

In other words, the special rate consideration happens in the 1980's for whatever reasons, and a person coming in—R.N. or pharmacist or whatever—gets a special rate. What has the experience been; has it been a negative fallout in morale, negative fallout on the personnel person that has been there for 12, 12 or 15 years?

Dr. GRONVALL. No, because the approval of a special rate applies to the entire job category, whether the person is new or has been there for many years. So the approval is not for special rates for specific individual people; it is for a job family.

So when a given medical center gets approval, all of the people in that category receive the rate increase. The effect on morale is positive for everyone in the work force.

Mr. ROWLAND OF CONNECTICUT. Good. Mr. Lindsey, would you like to follow up?

Mr. LINDSEY. You make a very good point and that is why we prefer to use the special salary rate authorization because it includes all of the employees in that category.

We do have other options which would not do that. For example, there is Section F—individual appointments at higher rates of pay.—where we could bring in an individual who had been working

in some other institution and pay that individual alone a higher salary. That does and would cause the morale problems of which you are speaking.

Mr. ROWLAND OF CONNECTICUT. Let me just follow up. For that salary increase then, across the board, all R.N.s at X-Y-Z Medical Center get an increase because of the competition. So you are going to retain those people and you are going to attract some of those new bodies that you need.

Is there a separate distinction for the budgetary reasons; does that local director have to absorb that, or is he always unsure every time he makes that request?

Mr. LINDSEY. When the request is submitted by the medical center director, we enter into immediate negotiation with him in terms of what he feels he can absorb within his own budget. Then we make that balanced judgment.

Mr. ROWLAND OF CONNECTICUT. So if he is smart, he is going to try to keep the other accounts up to snuff so that he can present the best face in the hopes that—Well, you should not comment on this.

Mr. LINDSEY. And if he has a sense of fairness and equitability, he would also look at the system, as well as his own individual situation.

Mr. ROWLAND OF CONNECTICUT. Again, I appreciate your remarks. It cleared up some of the misunderstanding I had and I appreciate your understanding of the unique position we are facing in the Northeast and hope that the budgetary responses will be there, too.

Thank you.

Mr. MONTGOMERY. Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman. Dr. Gronvall, I just have one more question. You referred to the Decentralized Hospital Computer Program twice in your testimony and while we explored this issue pretty thoroughly a few weeks ago in other hearings, I thought in these hearing records we ought to get your response to what would be the effect of placing this on hold for a few years.

Dr. GRONVALL. I believe that if we were required to place the entire DHCP System on hold for several years while a different approach was developed, that would be a very major setback to the management of our medical centers.

I have been remarkably impressed, as I have visited our medical centers, talked to people in the field, that the DHCP System has been developed and is being used and is being depended on to manage the medical centers.

The disruption of putting that on hold and impeding further developments and having to start over, again, I think would be a major setback at a time particularly where there are major new requirements to effectively and efficiently administer the system.

The eligibility revision is a good example where within just a very few months we were able to develop the software necessary to computerize the handling of the application process. I believe that the implementation of that eligibility revision is a real success story in administrative management.

I think a good deal of credit goes to the fact that we have an automated data processing system developed and administered by the VA. We could turn to our people to develop the necessary refinements, software additions to computerize this system, and we did that very expeditiously.

Mr. HAMMERSCHMIDT. I thank you. I know in addition to your very forthcoming response here that in those other hearings we had a number of other witnesses and other documentation from hands-on users of that system that agree totally with you. I wanted to get that into the record in these hearings.

Dr. GRONVALL. Thank you. I appreciate that.

Mr. MONTGOMERY. Thank you, Mr. Hammerschmidt. I would like to follow up. There is something that has not come out yet, about the Subcommittee on Appropriations holding up these funds. We are going to push all we can.

I have been out talking to the hospital people who operate these computers. They are satisfied with them; it is not a Cadillac system but it certainly is a system that is working. I am worried about the taxpayers; it is going to cost them a lot of money down the line. We need your help.

I still don't understand why the Appropriations Subcommittee—it is your system, you are the one who has the responsibility, yet they won't accept your word that you can make this system work. I am very concerned about that.

Something is going to break on this, and we will find out what the reasons were for this hold-up.

Dr. GRONVALL. Thank you.

Mr. MONTGOMERY. Having been kind to you, I would then ask you, why haven't you followed up on nurses when you saw the signs in the early 1980's, Dr. Gronvall— I know you weren't in that position—that there would be a shortage of nurses in the country? We knew this on the committee.

We were seeing it happen across the land. Are you taking any action? Are you going to request any special personnel funds to get the nursing situation cleared up for us?

Dr. GRONVALL. I would be pleased to respond to that. I think my perspective on that is that the personnel shortages and recruitment problems are in fact cyclic. That has been my experience before coming to the VA. It has been my experience in reviewing the VA experience.

In the early 1980's, it is clear that we were entering a period of shortage. The VA did many things to deal with that, including establishment of the scholarship program, acceleration of special salary rates and other steps.

Mr. MONTGOMERY. But you didn't ask for funding of that program last year, staff tells me.

Dr. GRONVALL. Those steps earlier had achieved some success. We have now begun to enter another period of shortage. Our 1988 budget includes a specific request for funds to reactivate the scholarship program. So we are taking specific steps, including that request for funds to deal with aspects of this problem.

Mr. MONTGOMERY. But you didn't request funding for the nurses' scholarship for several years.

Dr. GRONVALL. During a 2-year period, all of the evidence that we had and that other organizations, such as the American Hospital Association had, was that the production of availability of nurses was meeting the need. So we went through a period where we weren't having serious problems.

There are always some individual problems. So the judgment was that the scholarship program was not needed at that point.

Mr. MONTGOMERY. But you didn't request for 1986 or 1987.

Dr. GRONVALL. Correct. 1986 and 1987 we did not; in 1988, we have requested funding to reactivate the program.

Mr. MONTGOMERY. I think instead of coming up here and talking, I think you are going to have to take some action out there. We are willing to help you.

Mr. Penny.

Dr. GRONVALL. I appreciate that.

Mr. PENNY. Thank you, Mr. Chairman. I want to get back to the State Nursing Home Program. You raised in your testimony a question about Section 2 of H.R. 1659 with regard to States which may not complete the requirements for grant award before July 1, 1987, and might not be high on the new priority list.

Which states are at risk of such situation?

Dr. GRONVALL. Dr. Olson is here. He is the assistant chief medical director who manages this program. I think Dr. Olson could tell you the States where that potential exists.

Mr. PENNY. I would certainly like to know.

Dr. GRONVALL. Dr. Olson, I think you would need to come up and use the microphone.

Mr. OLSON. We have ten projects; that would be the State of Maryland, Massachusetts, Georgia; five in California, one in New York and one in Florida.

Mr. PENNY. I guess what I am trying to get at is whether they are really at risk of losing funding if Section 2 is adopted?

Dr. GRONVALL. May I comment on that?

Mr. PENNY. Yes.

Dr. GRONVALL. I think I can clarify that. Prior to the revision in the prioritization process for the State Home Grants Program, we had notified a number of States that funds would be available during fiscal year 1987 for their projects. We told them that, of course, to receive an actual grant they had to complete all of their requirements prior to October 1, 1987 to be eligible.

The new Prioritization Act requires establishment of a priority listing by July 1, 1987, and then the Administrator's ability to meet grants between July 1, 1987, and the close of this current fiscal year, would be mandated by the priority position of the individual project.

It is our judgment that there may be some State projects where we had already told the State there would be funds available this year; the State is taking steps to complete their action prior to October 1, but the priority for the project that may be established on the July 1 list may be low enough so that an actual grant will not be able to be made on that basis.

In that sense, we believe the State incurs an equity problem since they were earlier informed that funds would be available.

Mr. ROWLAND OF GEORGIA. Would the gentleman yield?

Mr. PENNY. Yes. Do you want to follow up on this point?

Mr. ROWLAND OF GEORGIA. I do want to follow up on that point. I just want to try to clarify something in my own mind. The States that were read out there, is it true that those States are at risk if we change the policy that we have set?

Dr. GRONVALL. Those States are at risk if H.R. 1659 as now written is adopted. It is on that basis that we have made a recommended legislative refinement of H.R. 1659 which would give the Administrator authority to make those grants if the States complete their funding action prior to the end of this fiscal year, independent of where that project might stand on a new priority list to be developed on July 1.

Mr. ROWLAND OF GEORGIA. As I understand, the Gentleman from Minnesota is offering such legislation.

Mr. PENNY. Section 2 of this bill makes effective July 1 the new priority process. But if the funding is set aside by July 1, these States are not at risk of losing out.

Dr. GRONVALL. Our understanding of H.R. 1659, if it is adopted as now written, is that the Administrator would not have authority to make a grant to some of those State projects if in fact their priority level as established on the July 1 priority list is below a certain level, in spite of the fact that the State was earlier told that funds would be available.

Mr. PENNY. But the States have known for some time that they needed to get money appropriated for their portion; that they should have had that money appropriated by now.

Dr. GRONVALL. But they had been officially notified by the Veterans Administration that they had to complete their funding action by the end of September 1987; not by the end of June 1987.

Mr. PENNY. It seems to me most State Legislatures, and this may not be true in California because they might go year-round, but most State Legislatures are going to be in and out of session by the end of May. If they are going to have the money appropriated, it is going to be appropriated in advance of July 1.

I am not sure that we are going to have a problem here at all, because if they do get the money appropriated, they have appropriated it in the past or they get it done within the next couple of months, they are still going to be at the top of the new priority list.

Dr. GRONVALL. They may not be at the top of the priority list.

Mr. PENNY. If the money has been appropriated, they would be.

Dr. GRONVALL. No. The prioritization that is now mandated by law takes into account many other factors beyond availability of State funding. That is the context in which I am saying that some of those projects, when subject to—

Mr. PENNY. The States that have been notified that they ought to get their State funding in order and, if so, then during this fiscal year funding will flow from Federal sources—

Dr. GRONVALL. Correct.

Mr. PENNY. But you didn't list for me which States have not yet passed an appropriation or set aside the money for their share.

Dr. GRONVALL. Perhaps, Mr. Penny, the matter is quite technical. We have submitted a legislative amendment to H.R. 1659 which we believe would solve the equity problem. Perhaps it would be best for us to supply to you, and we can do that immediately,

specific details about individual State projects, and why we have come to the conclusion that they might fall into a category where they would be too low on the priority list to actually receive a grant between July 1 and October 1, even though the State had been told earlier that they would have funds made available.

Mr. PENNY. I think we do need to see some more information on this. It seems to me that the key point is if the money is already set aside, States have been on notice for some time that they should be setting aside their share, that they should not be caught in that situation.

I don't think the list of States you gave me is necessarily the list of States that are going to have a problem.

Dr. GRONVALL. I believe your goal and ours is exactly the same and it is a legislative technicality that leads us to the conclusion that some of those States might in fact not be able to be funded this year. We want to resolve that. I think your goal is the same.

[Subsequently, the Veterans Administration furnished the following information:]

STATUS OF FY 1987 CONSTRUCTION APPLICATIONS

STATE	Project	Est. Grant Amt.(000)	Status of Processing
MD	24-003	3,047	Awaiting State Share and bid tabs
MS	28-001	4,388	Grant Awarded 4/23/87
MA	25-029	78	Awaiting resolution of life safety requirements
MA	25-030	80	Awaiting resolution of life safety requirements
GA	13-004	4,550	Awaiting bid tabs
MN	27-006	474	Grant Awarded 1/21/87
IL	17-010	144	Grant Awarded 4/23/87
PA	42-009	1,800	Awaiting formal application, historical preservation clearnace, review by State Single Point of Contact, environmental assessment or statement of categorical exemption, final drawings & specs, bids tabs. (Deferred by State)
CA	06-013	2,180	Awaiting formal application, historical preservation clearance, preliminary/final drawings and specs, State matching funds, and bid tabs
CA	06-015	1,991	
CA	06-016A	455	
CA	06-017A	1,322	
CA	06-018	2,365	
NY	35-002	16,510	Awaiting approval of EA, clearance from historic preservation, and bid tabs.
AR	05-002	195	Awaiting categorial exemption or EA, final drawings and specs, bid tabulations (State requires certificate of need which has been denied & legislative exemption proposed).
PA	42-008	4,091	Awaiting formal application, approval of EA, Single Point of Contract Review, State matching funds, final drawings and specs, and bid tabs. (Deferred by State)
RI	44-008	1,138	Awaiting preliminary/final drawings and specs, approval of EA, clearance from State historic preservation officer, adequate State matching funds & bid tabs.
FL	12-001	4,083	Awaiting formal application, approval of EA, preliminary and final drawings and specs, adequate State; matching funds, bid tabs. (Deferred by State)
TOTAL	.....	48,891	

Mr. PENNY. Thank you, Mr. Chairman. I don't need any additional time.

Mr. MONTGOMERY. The Chair recognizes Mr. Staggers.

Mr. STAGGERS. I won't take very much time. In your prepared testimony, you make reference to the different categories, A, B and

C. I don't know whether this is true or not, but during the recent district work period, I ran into some veterans who say there may be subcategories. Is that a possibility?

In Category A, are we classifying these people as POWs, service-connected? Are there subcategories in these categories?

Dr. GRONVALL. For purposes of our documentation and reports to Congress, we divide the Category A applicants into many subcategories. We separately identify, in response to legislative mandate, service-connected veterans into categories by percentage of service connection. We separately identify ex-POWs, etcetera, etcetera.

But the response to the request for a Category A veteran is independent of which of those subcategories he or she falls into.

Mr. STAGGERS. So there is no treatment priority?

Dr. GRONVALL. Correct; absolutely none.

Mr. STAGGERS. I liked your statement that we share the same goals. I would agree with that, and in your prepared statement, you talk about enhancing the image. I think that is a good idea, also, to attract new personnel. You are concerned about the high-quality health care, and of course, we can't do that without high-quality individuals. People are the backbone of the organization.

Dr. GRONVALL. Absolutely.

Mr. STAGGERS. I commend you for that acknowledgement, but I also would agree with the chairman; we need to just quit talking about it and get some of these people.

Dr. GRONVALL. Thank you.

Mr. STAGGERS. I yield back the balance of my time, Mr. Chairman.

Mr. MONTGOMERY. Thank you, Mr. Staggers. Mr. Rowland.

Mr. ROWLAND OF GEORGIA. I want to pursue this business about the personnel just a little bit further, because I am really concerned about that.

I believe that the nurses' organization of the Veterans Administration has indicated that it takes 6 to 12 months to obtain approval to use these special rates that we were talking about.

You had indicated earlier that you did not have to go through the Office of Personnel Management; that you were given very broad authority in dealing with this. If that is true, why does it take this long, 6 to 12 months, to get nurses?

Dr. GRONVALL. Let me ask Mr. Rudd to give some specific statistics about the time it takes to review those requests.

Mr. RUDD. On those authorities that the VA has directed authority for, the average processing time is 7 weeks. For those that require additional OPM review, that is an additional 6 to 8 weeks. That is the most recent data we have.

Mr. ROWLAND OF GEORGIA. Why is there an additional OPM review?

Mr. RUDD. Because that is required by statute.

Dr. GRONVALL. He was adding that for the Title 5 occupations, where that is mandated by law.

Mr. ROWLAND OF GEORGIA. I am talking about Title 38 right now.

Mr. RUDD. Title 38, the average processing time is 7 weeks. From the day we receive the request until it goes into effect.

Mr. ROWLAND OF GEORGIA. So the 6 to 12 months is really not correct?

Dr. GRONVALL. The figure that Mr. Rudd just gave is the Central Office time in review and action. The individual medical center, of course, has to take time identifying the problem, documenting it, developing the recommendation. So that is not the total time that it requires, from recognition of a problem to approval.

Mr. ROWLAND OF GEORGIA. I understand that. So most of the delay is at the local level and not at the Central Office.

Dr. GRONVALL. Time is required both at the local level and at the Central Office review.

Mr. RUDD. As we have developed an increase in the number of requests, of course, we have developed a backlog and we are taking several steps now to reduce that backlog, like assignment of additional staff, use of overtime, additional computerization—steps like that to keep up with the increased number of requests we are getting as the recruitment problem becomes more intense.

Mr. ROWLAND OF GEORGIA. Ms. Ferguson, are you satisfied that the time is at a minimum?

Ms. FERGUSON. I am satisfied with the new mechanisms in place in the Central Office, that it is moving rapidly now.

Mr. ROWLAND OF GEORGIA. I see.

Ms. FERGUSON. I think one of the delays matches that which Dr. Gronvall cited; the changes are so precipitous and rapid in the private sector, that it takes a time to assure that a station really gives us the best estimate in order that our nurses are competitive.

Mr. ROWLAND OF GEORGIA. Let me go back to Title 5 just a minute. As I understand it, it takes an average of about 6 weeks after notification of a request for this special salary rate. Does this include the 90-day advance notice requirement for the establishment of these special rates?

Mr. RUDD. Yes, that is within the 90 days.

Mr. ROWLAND OF GEORGIA. Then it doesn't take 18 weeks altogether; that is included in that period of time?

Mr. RUDD. From the time that the VA would make its review a special rate request for pharmacists, say, we send it to OPM; that takes an average of 6 to 8 weeks. That is counted within that 90 days, the 6 to 8 weeks I just referred to. They have a total of 90 days to act on the request, otherwise the request automatically goes into effect.

Mr. ROWLAND OF GEORGIA. Did I understand you to say pharmacists?

Mr. RUDD. Yes, sir.

Mr. ROWLAND OF GEORGIA. Is that under Title 5?

Mr. RUDD. Yes, it is.

Mr. ROWLAND OF GEORGIA. What is under Title 38?

Mr. RUDD. Nurses, licensed practical nurses, physical therapists.

Mr. ROWLAND OF GEORGIA. Pharmacists come under Title 5?

Mr. RUDD. Yes, sir. At the present time.

Mr. ROWLAND OF GEORGIA. Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you. Are there any other questions of our witnesses from Members?

If not, we have some questions that we would like to submit to you; if you would answer them, we would appreciate it.

We would like to thank you, Dr. Gronvall, and the other witnesses. You have been very helpful.

Dr. GRONVALL. Thank you.

Mr. MONTGOMERY. Ms. Elaine Lloyd, who is president of the Nurses Organization of the Veterans Administration, will introduce the other guest with her.

Good morning, Ms. Lloyd. You may proceed in any manner you would like. Your full statement will be put in the record.

STATEMENT OF ELAINE LLOYD, PRESIDENT, NURSES ORGANIZATION OF THE VETERANS ADMINISTRATION; ACCOMPANIED BY NOREEN SOMMER, LEGISLATIVE DIRECTOR

Ms. LLOYD. Thank you, Mr. Chairman and Members of the subcommittee. I am Elaine Lloyd, a registered nurse and president of the Nurses Organization of the Veterans Administration. I thank the committee for the opportunity to appear before you today.

I am accompanied by Noreen Sommer, a registered nurse and NOVA's Legislative Director.

NOVA applauds you, Mr. Chairman and the committee, for the decision to hold this hearing on recruitment and retention. NOVA is very concerned about the shortage of nurses and what that will mean to our Nation's health care and particularly to the veteran patient.

Registered nurses are the constants in the hospital. We are there 24 hours a day, 7 days a week. We are the observers, the monitors, the teachers, the clinicians who collaborate with the physician and other health care professionals in the care and treatment of hospitalized veterans.

With the historic low staff-to-patient ratios in the Veterans Administration hospitals, nurses are already running at full speed. Current estimates indicate the VA is from 4,000–8,000 nurses short of what is required to operate the system.

Any further loss of nursing staff is unthinkable when NOVA members throughout the country report acute shortages in their own VA hospitals. Nurses are lured from the VA to the private sector, which can offer more stable work schedules, often without rotating shifts, better patient-to-nurse ratios, higher salaries and better fringe benefits, including tuition reimbursement.

The solution to these shortages is not forthcoming because for the same reasons are leaving the VA, the VA is not competitive in recruiting RNs.

The December 1986 survey report said, "As a whole, the Agency is maintaining adequate staffing levels," when in fact 54.5 percent of our facilities reported a moderate to severe difficulty in recruitment and retention of registered nurses.

Reflect for a moment when one California hospital reported as having only moderate difficulty in September, but by November had closed 30 medical-surgical beds and 50 locked psychiatric beds. What has happened to those hospitals with serious and severe difficulty in recruitment and retention?

NOVA is alarmed with the survey data on the private sector pay comparison. How can the VA be expected to solve its recruitment and retention problems unless pay comparability is closer to 100 percent?

NOVA exhorts the Congress and the VA to work together to develop approaches to stop the hemorrhage of nurses from leaving the VA and to infuse the system with new blood. There are critical steps which can be taken and they are outlined in our prepared statement.

In summary, these include comparable salaries, including Saturday premium pay; educational support and realistic workloads. NOVA requests this action on behalf of the competent and caring professional nurses working in the VA system who wish to continue with the mission of providing care that will assist veterans in maintaining or regaining health, learning to live with disability, or dying with dignity and comfort.

Thank you.

[The prepared statement of Ms. Lloyd appears at p. 61.]

Mr. MONTGOMERY. Thank you, Ms. Lloyd. You are a member of the Veterans Administration?

Ms. LLOYD. Yes, I am. I have worked 15 years in the Veterans Administration as a clinical nurse specialist.

Mr. MONTGOMERY. Where are you located?

Ms. LLOYD. In Palo Alto, in the spinal cord injuries center there.

Mr. MONTGOMERY. Ms. Sommer?

Ms. SOMMER. I am also a registered nurse. I have been with the Veterans Administration 2 years, in Houston, Texas, and for the past 10 years at the Palo Alto VA Medical Center, in spinal cord injuries, as a public health nurse.

Mr. MONTGOMERY. Thank you. Do you have a statement?

Ms. SOMMER. I don't have a statement. I am simply here to lend support and help answer any questions.

Mr. MONTGOMERY. I don't think she needs any support, but we are very glad to have you here.

Is this the first time you have testified?

Ms. LLOYD. Yes.

Mr. MONTGOMERY. You are doing well. Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Mr. Chairman, I don't have any questions, but I do want to thank Ms. Lloyd and Ms. Sommer for being here and testifying, and bringing us this information to the committee. Thank you.

Ms. LLOYD. Thank you.

Mr. MONTGOMERY. You have made a good statement. What is the key, Ms. Lloyd, to attract qualified nurses into our system? What do we need to do in your opinion?

Ms. LLOYD. I think some of the recommendations that came out of the study that was done on recruitment and retention in 1980—looking at reasonable workloads, and so there may be need to be increases in the staffing allocations in the VA, so that those workloads can be reasonable.

I think we are in a day and age of high technology and the VA is certainly a high tech area. We have wonderful equipment to use, but that changes the complexion of the work and you need more people to man and do that.

I think the rotation of shifts—recently a young woman said to me that she was leaving the intensive care unit, having worked there 5 years. She has 17 years of service in the Veterans Administration and she is leaving. Her head nurse said to her—what could

I do to make you stay? She loves intensive care nursing, and she said—If I didn't have to rotate, I would stay.

I think that there isn't the ability for the Veterans Administration, with the staffing allocations in nursing, to take care of that. It is so tight right now that one call-in can make the difference.

Recently a head nurse had to stay on duty 4 hours and ask her night nurse to come in early 4 hours so that that evening shift could be covered. There was absolutely no flexibility in that particular work area to even allow for that, just somebody getting sick, unplanned for.

Mr. MONTGOMERY. Thank you. Dr. Rowland.

Mr. ROWLAND OF GEORGIA. Thank you, Mr. Chairman. I want to welcome my colleagues in health care here today. I think your testimony was very good. I do want to ask you a couple of questions.

Ms. Lloyd, you said in your testimony that the special pay rates in effect for nurses may not be updated yearly. This is conflict with the regulations that OPM has for this program.

Has your organization had widespread reports on not updating the special rates, or just isolated reports?

Ms. LLOYD. I don't have widespread information on that, but perhaps could get that for. I can only speak from our experience in Palo Alto. We were on special rates and they had not had any changes for 3 years that I was aware of, and recently had a substantial change in December of 1986.

Mr. ROWLAND OF GEORGIA. You also quoted 15 recommendations in your statement from the 1981 study. Was that in response to the study requirements of Public Law 99-330?

Ms. LLOYD. Yes. 96-330.

Mr. ROWLAND OF GEORGIA. What three or four recommendations out of those 15 would you place the highest priority on?

Ms. LLOYD. I think the recommendations on page 4, Item 2. Nurse staffing levels must be established and maintained in accordance with standards based on reliable measurements of workload. Item 4, on page 5; the use of flexible work schedules as provided for by Public Law 97-221 should be encouraged. I would also add Saturday premium pay in there.

Item 8, staffing patterns should be developed to eliminate rotation to different tours of duty. Item 11, tuition reimbursement should be offered to all nurses enrolled in courses which enhance their work.

I think those are some of the major ones that I would emphasize.

Mr. ROWLAND OF GEORGIA. Thank you. This committee, is thinking in terms of specific skills for nurses. Do you think it would be useful if we thought in terms of specialized care, like intensive care unit nurses, or should we think in general terms about the shortage of nurses in the VA? Is that question clear to you?

Ms. LLOYD. Not quite.

Mr. ROWLAND OF GEORGIA. Should we think more in terms of specialized nurses, or should we think more in terms of general nursing care?

Ms. LLOYD. I think nursing today is very specialized, and I think we need to continue to provide education for the specialized care that veterans need.

I think if your question in relationship, should we pay nurses in special areas special differences—

Mr. ROWLAND OF GEORGIA. No. The context of the question is, should we think in terms of nurses who are more specialized, or should we think in terms of general nursing for the shortages that exist?

Ms. LLOYD. I think we need general nurses and oftentimes, I think particularly new graduates come out of school as a generalist, and I think with experience, then learns to specialize. If we have enough staffing, we can provide education for nurses often on the job to help them specialize and help them become skilled in particular areas.

Mr. ROWLAND OF GEORGIA. I think we need to think more terms of general nursing, and then they get their training to become specialized.

Ms. LLOYD. I think so.

Mr. ROWLAND OF GEORGIA. I see.

Ms. LLOYD. Tuition reimbursement would help in that specialization, also, as nurses could go and pursue additional advanced degrees to specialize in certain areas. We need those special people, too.

Mr. ROWLAND OF GEORGIA. Is there some type of non-nursing personnel that would help to relieve some of the pressure on VA nurses that could be recruited?

Ms. LLOYD. That are being recruited?

Mr. ROWLAND OF GEORGIA. Non-nursing personnel that would relieve some of the pressure on nursing.

Ms. LLOYD. Yes. I think all of the support services—if there are shortages that exist in ward secretarial help, or transportation services, it cuts into the nursing time. Those would all be very supportive to the nursing staff. I think keeping the support services fully staffed helps the registered nurse and nursing, in general.

Mr. ROWLAND OF GEORGIA. One final question I would like to ask you. Have you been asked, or have your nurses been asked to have some input into what could be done for the load standards that are being developed by the VA?

Have you been asked to have some input?

Ms. LLOYD. Not at this time.

Mr. ROWLAND OF GEORGIA. That is being developed without consulting you?

Ms. SOMMER. I believe surveys have been done of the hospitals, themselves. As an organization, we have not been consulted. I think as staff in individual health centers there has been some consultation.

Ms. LLOYD. There is probably nursing involvement in a different way, other than through this organization.

Mr. ROWLAND OF GEORGIA. Thank you, very much, for being here today. Mr. Chairman, my time is up.

Mr. MONTGOMERY. Thank you, Dr. Rowland. I would like to thank our witnesses for being here today. You have been very helpful, and we thank you for coming this long distance and appearing before this committee. Thank you, very much.

Ms. LLOYD. Thank you.

Mr. MONTGOMERY. The next witness is Dr. Paul Schafer. We are very familiar with Dr. Schafer, executive director of the National Association of Veterans Administration Physicians. Thank you for the help you have been over the years, Dr. Schafer.

Your full statement will be placed in the record.

STATEMENT OF DR. PAUL SCHAFER, EXECUTIVE DIRECTOR, NATIONAL ASSOCIATION OF VA PHYSICIANS

Dr. SCHAFER. Mr. Chairman, I can attest that there once a time, after World War II, in the late 1940's and early 1950's, when those of us charged with major health care responsibilities in the academic and private sectors actually despaired over our inability to match the monetary and other inducements offered by Veterans Administration hospitals.

They were then able to hire away from us the best of the whole spectrum of health care providers and supporting personnel.

If the personnel pendulum could have then been said to have then been said to have swung too far in favor of the VA hospital, it truly now can be said to have moved even further in the opposite direction.

We now are only able to recruit clerks, typists, secretaries, administrative assistants of the most marginal caliber, and to make matters worse, as soon as they acquire skills on the job, we lose them to far more attractive opportunities they can easily find elsewhere.

This observation extends to other Title 5 employees who serve in our centers.

The situation becomes an outright disaster in respect to Title 38 personnel. The shortage of nurses, about which you have heard, is so acute that we are actually in the process of closing down whole wards and curtailing many essential functions.

It is true that we are able to recruit young physicians just out of residency training, but we can't keep them. Many stay with us only long enough to study for their specialty board examinations and then they quickly leave for what are perceived to be greener pastures soon after getting those certifications.

You can be sure that doctors, nurses and other Title 38 personnel hear horror stories as to the way their predecessors have been treated. Why make a career commitment, become captive in the golden bonds of years of service and then suffer a similar fate?

Not forgotten is the holiday surprise of December 1981 when P.L. 97-72, without a grandfather provision, changed the formula for calculating annuity benefits. This took away tens of thousands of dollars from hundreds of doctors and nurses who, in good faith, had planned their entire professional lives on a set of retirement rules now cancelled retroactively over their entire careers.

Also, not forgotten is the arbitrary and capricious 1982 decision by then-Administrator Nimmo to take away $5,000 of VA physicians' Special Pay. Though part of this loss has been recovered, each VA physician each year loses $2,682. This irrationality cannot have a favorable impression on young VA doctors, as they earn promotions only to find that they earn less.

NAVAP tried without success to correct this anachronism in the courts. It is still possible of correction legislatively.

Morale among our health care workers is adversely affected by many other factors.

It is clear for all to see that the present Administration's attitude toward Federal employees is less than that of a warm friendship.

Privatization of veterans health care is perceived by many as a very real threat, and why not? We see McDonnell Douglas well on the way to taking over our data processing capabilities. Can the Hospital Corporation of America, National Medical Enterprises, or other giant health-care-for-profit organizations be far behind?

Our health care delivery system may literally self-destruct under the weight of its own managerial and administrative burden, which has already grown to obscene proportions.

It does not go unnoticed that Agency leadership over the last few years has become somewhat less than stable. In the span of 5 years, we have had three administrators and three chief medical directors. Each brings a new style, priorities, and management team. Thus we have to cope with the changing emphases of MEDIPP and DRG-RAM and other acronymed-programs on the horizon.

Many ask the question, where does the money go? The Congress regularly appropriates veterans medical care funds in excess of the President's budget request, and generally in the order of the Agency's identified current services requirements. Yet at the facility level, we have inadequate supplies and we are seeing sharp curtailment of staff, often orchestrated secretly and cynically by Byzantine cabals.

We have just begun to function under a directive greatly curtailing beneficiary travel. This is a most cruel way to cut expenses. Many veterans see the 100-mile exemption as a penalty over which someone, somewhere must be gloating.

If we are truly interested in first-quality health care for our veterans, I suggest the following actions be taken: Discriminatory grandfathering differences between Title 38 and Title 5 annuity calculations must be eliminated.

The continuing $2,682 reduction in VA physicians Special Pay should be stopped.

The present Administration's attitude toward Federal employees probably cannot be changed, but the turning back of McDonnel Douglas and aggressive take-over efforts would send an appropriate message to America's health-care-for-profit corporate giants.

The Agency should be required to document the last decade's changing numbers of administrative personnel as compared to those of us who actually take care of patients.

The Agency's personnel practices and the complexities of affiliation need a complete overhaul.

Monetary and creative other inducements must be increased well beyond current levels. We only get what we are willing to pay for.

Why not get the answer to the question—Where does the money go? Is it diverted or wasted as it goes through Central Office hierarchy, to regions, to districts, to facilities, and finally to its only reason for being: namely, to take care of our veteran patients?

I thank you.

[The prepared statement of Dr. Schafer appears at p. 72.]

Mr. MONTGOMERY. Thank you, Dr. Schafer. As usual, you are an excellent witness. You wrapped it up well, and you give us some points to look at and we will do that.

Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Mr. Chairman, I don't have any questions, but Dr. Schafer always bring us good testimony and we appreciate what he brought us this morning. Thank you, Dr. Schafer.

Mr. MONTGOMERY. Let me ask a question before recognizing Dr. Rowland. What would be your position if the VA had para-professionals, technicians, to fill the staffing vacancies of nursing, pharmacists, or other health professionals? Paramedics, I guess, is what I am saying.

Dr. SCHAFER. I think we missed a great opportunity after the Viet Nam experience. We certainly had a whole host of very, very competent people that our medical professions did not capture in any sort of a meaningful way. I think that is a tragedy that that happened.

Specifically, in respect to the program for physician assistants. I don't believe that ever was given the kind of emphasis it should have had, nor the support that obviously would have been needed for it to become a meaningful and viable way to address some of the problems that we now face today.

The same attitude I believe would be correct as it applies to all of the other efforts that have been made. I think we have made tremendous success in terms of utilizing licensed practical nurses, in support of the nurses shortages.

But I have no present creative ideas to present to you as to how we can recapture the loss that we have suffered.

Mr. MONTGOMERY. Thank you, sir. I have one other question for the record.

Dr. Rowland.

Mr. ROWLAND OF GEORGIA. Mr. Chairman, I want to ask a question about McDonnell Douglas. I assume you are talking about DHCP?

Dr. SCHAFER. Yes, sir.

Mr. ROWLAND OF GEORGIA. Okay. You mentioned McDonnel Douglas a couple of times in there. You seem to think that it is a threat to the medical personnel in the VA if in fact McDonnel Douglas has its way; is that correct?

Dr. SCHAFER. Yes, I think it would be an absolute disaster. It would greatly, greatly compromise our ability to deliver first-quality medical care. It certainly would greatly compromise our ability to recruit young, capable physicians who actually require modern data processing technology such as we already have in place.

You heard Dr. Fletcher just 2 weeks ago today, as an example of what imaginative, able, competent, young clinicians can and have done. That is a very important instrument in terms of our ability to recruit such people. These are the people the Veterans Medical Program desperately needs.

Mr. ROWLAND OF GEORGIA. You think we are in danger of losing those physicians if we lose our DHCP?

Dr. SCHAFER. I think if we withdrew our present capability and replaced some years hence with some other capability, we not only would lose some physicians that we now have, whose very careers depend on that capability, but we would greatly compromise our ability to recruit new like personnel.

Mr. ROWLAND OF GEORGIA. Would that be assuaged somewhat if the Appropriations Subcommittee that is holding this $35 million were to acquiesce?

Dr. SCHAFER. I hesitate to answer that question because I must select my words very carefully. There is no question but what the careful incremental development of the DHCP into its enhanced core program modules, which of course would be funded by this $35 million—that is an absolute necessity.

If I picked only one of those programs—radiology, my goodness. In our medical centers, we desperately need that function computerized. That, alone, would be a sufficient reason in my opinion why the $35 million ought to be released.

But not after carefully selecting my words in advance, I would like to make one further comment. We have had a most remarkable experience in just the last 48 hours.

It has seemed to me that one of the reports that has been highly featured by the Appropriations Committee is that of their own staff and Investigation's staff. And, as you know from that report, the DHCP is represented almost as if it were being treated by an adversary, such as McDonnel Douglas.

The principle in respect to that report is an individual I have never met, a Mr. Van der Griff. You recall from my testimony 2 weeks ago, I indicated that the National Association of VA Physicians was well underway in terms of trying to develop a fair set of criteria for proper evaluation of programs such as this. Since this particular report seemed to fail by any preliminary evaluation of criteria, I had my personnel call Mr. Van der Griff to ascertain what kinds of rules and policies and procedures and manuals and instructions they followed in arriving at reports such as they had submitted on the DHCP.

I was absolutely appalled to find that there are no rules. There are no procedures. The answer given by this gentleman was—we sent people out in the field and they asked questions and then we take those answers and work with them and make a report.

I couldn't believe such laissez faire treatment of such a very serious matter. So I have written to Mr. Van der Griff to make sure that he understands that we were not interested in the specific data presented in that report, or necessarily in their conclusions. We merely wanted to know if they didn't have some better method than just, laissez faire, asking questions.

Mr. ROWLAND OF GEORGIA. I believe you have answered my question.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you. To follow up on that, we have some veterans' organizations here, and also people who represent the medical profession of the Veterans Administration. I am concerned unless you call in from the different VA centers all around the country, and let the Appropriations Committee know your position. I don't know what is going to happen. It is such a serious

problem. If the veterans' organizations want good health care, they are going to have to get the Appropriations Subcommittee to move. We have had closed meetings with them.

We have had Dr. Gronvall, the Administrator, in effect begged them—Please let us go ahead and buy these computers. It means health care.

You pointed out radiology. If the veterans' organizations don't get going and the hospitals are doing a pretty good job, of administrators calling Members of the Congress and they have talked to Mr. Boland and other people on the subcommittee—we are not going to win it.

I think we can win it if we turn up the heat and let them know on that staff on the Appropriations Subcommittee what they are doing. Basically, what you are saying, they are endangering peoples' health. We are not going to be able to give them the proper health care that they are entitled to.

Is that kind of the bottom line?

Dr. SCHAFER. Yes, Mr. Chairman. If I read the situation correctly, and I believe that I am correctly advised and informed, were the McDonnel Douglas efforts to succeed, it is not only that we would lose the programs that are included in the enhanced core, but we would be faced with an horrendous problem in having to dismantle the DHCP as it now exists.

The many people who now have become trained in the methodologies of the MUMPs language, data-based management system, and particularly the file manager—the file manager which has been used to build every single one of the many, many programs we have—their training have all been for nought because they would have to learn a new language, COBOL. They would have to learn whole new methods.

We are talking about years of non-productivity, plus the fact that we would immediately lose the programs that are in the initial core; our registration, our whole MAS methodology for admission, discharge, transfer, clinic scheduling, out-patient pharmacy, and so on.

This is something that I cannot imagine could be justified by any thoughtful group.

What the Appropriations Subcommittee on HUD and Independent Agencies is doing, I have to regard as irrational and insensitive and I join you in wondering what is going on.

Mr. MONTGOMERY. That is my problem. I can't figure it. It is something we are not reading, and it is going to come out.

I wrote Sandy McDonnel of McDonnel Douglas a letter. I think it is going to get his attention. I would rather not—I will let him divulge what is in the letter.

Dr. SCHAFER. As you know, I wrote him a letter, too, sir.

Mr. MONTGOMERY. Yours was a lot tougher than mine. I have seen yours.

Dr. SCHAFER. Yesterday, I had an answer to that letter from John McDonnel, the president, rather than the Chairman of the Board Sanford. It was a remarkable letter. I will see that you are furnished a copy of it.

Mr. MONTGOMERY. Okay. Any other questions? If not, thank you, very much.

Dr. SCHAFER. I would appreciate it, very much, Mr. Chairman, if my entire report could be included in the record.

Mr. MONTGOMERY. Without objection, so ordered.

Dr. SCHAFER. Thank you, sir.

Mr. MONTGOMERY. I would like to have Mr. Frederick A. Traill, Member, Legislative Committee, National Association of State Veterans Homes come up.

You might introduce Mr. Friedman, and your full statement will be put in the record.

STATEMENT OF FREDERICK A. TRAILL, MEMBER, LEGISLATIVE COMMITTEE, NATIONAL ASSOCIATION OF STATE VETERANS HOMES; ACCOMPANIED BY DR. MELVIN H. FRIEDMAN, MEMBER, LEGISLATIVE COMMITTEE

Mr. TRAILL. I just have been told it is Dr. Friedman, my counterpart on my left.

Mr. Chairman, and Members of the subcommittee, it is a privilege and a pleasure for me today to appear here and present the views of the National Association of State Veterans Homes concerning H.R. 1659 on issues that are of great importance to our members.

I am Fred Traill, Chairman of the Association, Liaison Committee and a member of the Legislative Committee. With me today is Dr. Melvin Friedman, also a member of our Legislative Committee.

Initially, I want to extend the deep and sincere appreciation of the National Association of State Veterans Homes to you, Mr. Chairman, and to Members of this committee for your on-going efforts to improve this most important program that directly affects both the health care of veterans and veterans homes.

As noted in the Association's written testimony, the State homes provided 4,679,406 days of care for the veteran population of the United States during fiscal year 1986. The per diem payment paid through the Veterans Administration for these days of care averaged $13.54 across the three levels of care provided.

I note that 2,922,695, or 62.5 percent of the total days of care are nursing home care. The per diem increase proposed by H.R. 1659 is extremely welcome to the Association and is viewed as a positive sign that Congress wants to keep the Federal share of the cost of supporting veterans in State homes in some sort of equitable relationship.

Your action is particularly welcome when put in the context of developments at the State level, two of which I will cite for information.

In Oklahoma, the Governor announced his intent to eliminate the State Home Program citing economic difficulties as the reason. When the Oklahoma Legislature indicated it would not accept this approach, the Governor's fall-back position which I understand is still under discussion, is a 30 percent across-the-board in State Home Program funding. That is a very crippling cut.

In Michigan, my own State, the construction grant application for a third facility is in the process of being withdrawn as a part of continuing effort by the Governor and by the Legislator to reduce the size of State government.

The National Association of State Homes would again encourage and request that the per diem rates paid to State homes for all three levels of care be put on some method of annual review as a part of this legislation. Past and current methods of reviewing the Federal participation in the State home program result in annual increases in the cost to the States of operating these homes since these homes are no less subject to inflationary pressures than are other programs operated directly by the Veterans Administration, or those services for which the VA contracts.

The continuing recalcitrance of the Veterans Administration to support equitable per diem payments in State homes fuels the arguments of those State governments and legislatures who more and more openly question why the States are in the business of caring for veterans in the first place.

The National Association of State Veterans Homes commends the Congress in its efforts to increase the funding of the Construction Grant Program and to facilitate the entrance of new States into this shared service program for veterans.

However, we must reiterate that operational funding by the Federal Government on an equitable basis is absolutely crucial to efforts to attract new States into the State Home Program, and of equal importance, to retaining those States already providing services to the Nation's veterans.

Mr. Chairman, this concludes our remarks and we thank you for allowing us to testify and work with you and your professional staff on this important endeavor. We would be pleased to respond to questions from the Committee, if you so desire.

[The statement of the National Association of State Veterans Homes appears at p. 77.]

Mr. MONTGOMERY. Mr. Traill, do you run a nursing home?

Mr. TRAILL. Yes, sir. I have a 700-bed facility in Grand Rapids, Michigan.

Mr. MONTGOMERY. I met you when I addressed your group several weeks ago.

Mr. TRAILL. Yes, you did.

Mr. MONTGOMERY. Mr. Hammerschmidt.

Mr. HAMMERSCHMIDT. Mr. Chairman, I am going to forego any questions but we do very much appreciate Mr. Traill's testimony and Dr. Friedman's appearance before the committee.

Mr. MONTGOMERY. Dr. Rowland.

Mr. ROWLAND OF GEORGIA. Mr. Chairman, I do have a couple of questions. I have been very much interested in this DRG problem that we have had since 1983, and its affect on the VA, also.

You referred in your testimony to the increased number of severely disabled veterans in State veteran homes as a result of the implementation of this DRG-based funding mechanism for VA centers. Can you tell me what data you have specifically gathered to document this trend?

Mr. TRAILL. In terms of specific data, the Association has not collected specifics. I can cite what I see in my own facility, if this is helpful.

When I came there 8 years ago, as an example, there was a rare admission coming to our door by ambulance. Well over 50 percent

of our admissions now are coming in by ambulance, and that we do check.

What we see as the end stream to us of DRGs, both from the local and the VA hospitals, is quicker and sicker is the way patients are coming to us.

Mr. ROWLAND OF GEORGIA. Would it not be a good idea if we could gather some kind of information and document it and have it on record so that when we were asked we could say this is specifically what happened. I would like to make that suggestion.

Another question: I note that the corrections to H.R. 1659 that you mentioned during your statement will be made during the mark-up of this bill. Also, in your statement you suggested an annual review in adjustment of the State home per diem rates.

How would you recommend such a review to actually work?

Mr. TRAILL. We would prefer that this body be the reviewing body. We have suggested in the past that the targets should be about 30 percent of the VA rate of providing nursing home care, domiciliary care, or—not hospital care, but there is a lower level of hospital care that the VA provides which we equate to the hospital care in State homes.

We have suggested this be done in the past. Perhaps it is an idea whose time is coming.

Mr. ROWLAND OF GEORGIA. One last question. You referred in your testimony to the possible adverse impact on the cost of operations of many State home domiciliaries from the new VA guide. The name of the guide is "Guide for Inspection of State Veterans Homes, Domiciliary Care Standards."

Would you be specific about the areas of potential adverse effects?

Mr. TRAILL. I can be in my own facility, and I will ask Dr. Friedman if he has had the opportunity to review. We took the new VA domiciliary standards, which we received in mid-March, and have costed those out. To do the job right—there are two ways of doing it. One is to try and find out how you can paper comply with the standards and the other is to do the job right.

To do the job right, it would cost us about $300,000 in additional staffing at the Grand Rapids facility because of the very heavy emphasis on coordinated treatment programs, rehabilitation services, drug and alcohol therapy services, things which are not normally provided in the domiciliary setting.

In our dom, which is really operated as a part of a nursing home complex, still this increase would apply.

Mr. ROWLAND OF GEORGIA. Thank you.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Mr. Traill, I don't know if you have had a chance or not to determine how much this additional per diem would cost the Veterans Administration. Do you have any figures, raising that from $17.05 to $20 a day?

[Pause.]

From $7 to $9, and then from $17.05 to $20.35.

Mr. TRAILL. Mr. Chairman, I don't have that as a specific figure. What the cost would be may be something the VA would need to provide you.

Mr. MONTGOMERY. If you did come up with some figures, we would appreciate it.

For the record, the Congressional Budget Office said it would cost an additional $14 million per year.

Mr. TRAILL. Mr. Chairman, all I know for sure is that when you are dealing with a $28.6 billion budget, you round off more than we are.

[General laughter.]

Mr. MONTGOMERY. I think, too, that the States do have some responsibility, but when we get State Legislatures to go along with putting up funding, it is pretty hard to go back and continue to ask money, but I think you have to depend on most States to operate State veterans nursing homes for funding each year; is that correct?

Mr. TRAILL. I didn't understand the question.

Mr. MONTGOMERY. What I said was, do you have to depend on the State of Michigan to help you operate your State veterans nursing home?

Mr. TRAILL. Oh, yes, sir. The average across the board State support of the State Home Program is over 50 percent throughout the system.

Dr. FRIEDMAN. Mr. Chairman, I think another question which one might want to posit is, it may cost the VA an additional $14 million, but in the absence of those funds, if these veterans are not in the State nursing homes, where would they be? Then I think you are looking at, rather than a $20.35 per capita, you are probably look at something closer to $100 or $125 per capita.

Mr. MONTGOMERY. It would cost that much to have them in a nursing home that is totally operated by the VA?

Dr. FRIEDMAN. Yes, sir.

Mr. HAMMERSCHMIDT. Would the chairman yield? I just wanted to comment facetiously on Mr. Traill's facetious remark on the rounding off of figures. You know, the budget process both downtown and up here deals in blue smoke and mirrors anyway, and that is they round off millions of dollars. But when you get to the Appropriations Committee, it is an entirely different story. They can to cross all the t's and dot all the i's and they get down to specific dollars. They have to know what those dollars are.

Mr. TRAILL. I understand. I stand properly chastised.

Mr. MONTGOMERY. Thank you, very much for being here. You have been helpful. Thank you, very much, Dr. Friedman and Mr. Traill.

We would like to invite Panel I up, and because we want to vote on this bill, if you could submit your statement in full, that would be helpful and make brief comments.

Mr. David Gorman, of the Disabled American Veterans; Mr. James Magill, of the Veterans of Foreign Wars; and Mr. DeGeorge, of the Paralyzed Veterans of America.

STATEMENT OF DAVID GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. GORMAN. Thank you, Mr. Chairman. It is a pleasure to be here this morning. As you well know, Public Law 99-272 contained

provisions dramatically revising the criteria governing the eligibility and the provision of VA health care services.

The major provisions of that legislation mandated the VA to provide hospital care to a specifically defined category of veterans, established a means test for other categories of veterans, and authorized VA to recover the reasonable cost of medical care provided to non-service connected disabled veterans by simply billing the veterans' private health insurance companies.

Mr. Chairman, since the implementation of this Act, we are unaware of any significant problems that have been encountered with respect to veterans' eligibility for care, or the actual provision of care.

It is our view that the intent of this Act to provide care to service-connected and truly needy disabled veterans is being met in an adequate fashion.

With respect to the issue of the ability of the VA to recruit and retain qualified health care personnel, there has been much anecdotal information pointing to the Agency's difficulty in this regard. During January of 1987, a VA study was released which captured significant information regarding staffing characteristics of registered nurses, licensed practical nurses, nursing assistants, occupational and physical therapists, as well as pharmacists.

The survey revealed that the overall recruitment and retention situation for these professions was favorable at only about 47 percent of the VA's medical facilities. It was further revealed that 23 percent of the VA's facilities were experiencing moderate difficulty in recruitment and retention, 21.5 percent experienced serious difficulty, and 9 percent experienced severe difficulty.

Although there were small Agency-wide net gains for licensed practical nurses and registered nurses, there were net losses for occupational therapists, physical therapists, pharmacists and a large loss of nursing assistants.

Mr. Chairman, the major problem area of the Agency's ability to recruit and retain these health care professionals are similar across all disciplines, such as salary differentials, workloads, educational opportunities, family reasons and the need for employees to relocate.

Our written testimony recommends certain administrative actions and legislative suggestions which we believe will assist the VA in overcoming these identified areas.

Mr. Chairman, we fully realize that the nursing profession is entering an era that will, in the near future, witness a crucial shortage of registered nurses. This situation will impact not only in the VA, but the health care industry as a whole. Thus, it appears to be of critical importance that the VA have the ability to provide enhanced incentives in order to be competitive with the private sector in attracting health care professionals.

Although there has been Agency-wide net gains in the number of registered nurses currently employed, we have been informed by a number of VA nurses that there currently exists a very serious problem that demands immediate Agency attention. This situation concerns the disproportionate ratio of nurses to patients.

We have been apprised of times where there was only one registered nurse on duty on a given ward with the responsibility of

caring for as many as 68 patients on that shift. Not only is this unacceptable as far as the individual nurse is concerned, but more importantly, we cannot conceive of how quality medical care can possibly be provided.

Mr. Chairman, this causes both emotional and physical drain and is largely responsible for many of those dedicated professional nurses choosing to leave the VA health care system.

We are convinced that the VA immediately needs to address this concern and move in a positive direction to improve staff-to-patient ratios.

In conclusion, Mr. Chairman, we are pleased to support H.R. 1659, a measure that would increase the per diem rates payable by the VA to the State veterans homes, as well as to provide the VA to make transition year construction grants after July 1, 1986.

Thank you, very much.

Mr. MONTGOMERY. Thank you, Mr. Gorman.

[The prepared statement of Mr. Gorman appears at p. 88.]

Mr. MONTGOMERY. Mr. Magill.

STATEMENT OF JAMES MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS

Mr. MAGILL. Thank you, Mr. Chairman, for the privilege of appearing before this distinguished subcommittee to present the views of the Veterans of Foreign Wars of the United States with respect to the VA's implementation of medical care eligibility reform provisions of Public Law 99-272; the status of recruiting and retention of VA health care personnel; and, H.R. 1659.

As you know, P.L. 99-272 made significant changes in the criteria used to establish eligibility for VA health care. While the Veterans of Foreign Wars supported the eligibility reform approach advanced by the Congress, we also stressed the importance of having a sophisticated and valid reporting procedure to ensure that the full intent of the law was being carried out.

The VA is devising a complex and comprehensive reporting procedure. As it is being fine-tuned, the VFW has been evaluating it and providing input to ensure that it is a useful tool.

The VFW already has suggested refinements and posed some questions it believes still makes the reporting procedure as accurate as possible.

The VFW is pleased that the VA seems to be making an effort to help the VFW and Congress judge the effectiveness of Public Law 99-272. The VFW will continue to do all it can to assist in this effort.

We were also asked to comment on the recruitment and retention of VA health care personnel. While it appears for the most part, the recruitment and retention of VA physicians is at an acceptable level, there is a severe problem in the recruitment and retention of allied health care personnel.

Of this group, nurses, pharmacists and therapists are at a critical level.

Of utmost importance, the VA must become competitive with the private sector in recruiting and retaining health care personnel. In

my prepared statement, I list ways in which the VA can become competitive again.

The VFW strongly believes the VA must address their recruitment and retention problems with a long-term solution. The quick-fix simply will not work. The VFW in past testimony before this subcommittee has expressed its concern for the care and well being of our elderly veterans; the need for extended care by these veterans is increasing and will continue to do so well into the future.

The VFW supports passage of H.R. 1659, which provides for an increase in per diem reimbursement rates to the State veterans homes.

This concludes my statement, Mr. Chairman, I will be happy to respond to any questions you have.

[The prepared statement of Mr. Magill appears at p. 93.]

Mr. MONTGOMERY. Mr. DeGeorge. Glad to see Dr. Mather here today; we know him very well. Go ahead, sir.

STATEMENT OF FRANK DE GEORGE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; ACCOMPANIED BY DR. JOHN MATHER, ASSOCIATE EXECUTIVE DIRECTOR OF MEDICAL AND RESEARCH AFFAIRS

Mr. DEGEORGE. Thank you, Mr. Chairman. I, too, wish to express my pleasure that Dr. Mather is accompanying me here today. He is an asset to Paralyzed Veterans of America, I must say. I would also comment that our National Service Director, Mr. Gabby Hartnett, is also in the audience. I think that is worthwhile to mention, as well.

Mr. MONTGOMERY. We would like to welcome Mr. Gabby Hartnett, he has been an old friend. I am glad to see him back on the Hill.

Mr. DEGEORGE. Mr. Chairman, we do want to commend you and the Members of the subcommittee for your efforts and purpose for this hearing this morning. We do believe they are consistent with your efforts of the past.

As a matter of what the purpose of this hearing is today, it not only is a matter of what veteran is entitled to what care and when by the Veterans Administration, and it is not only a matter of what dollars will or will not be provided to programs for the Veterans Administration, but in the final roll of the dice, we are talking about life and death issues as it pertains to the veterans of this country.

In fact, the teaming of the two issues here today are and do go well, hand in hand. I wish that I could express what it means when care is not provided and when there is staff unavailable to provide the care when you are need of such care. I would probably go on in great length in expression of those kinds of concerns, having experienced some of those concerns myself in the past.

I would also add the caveat that when there are staff available and when they do provide the quality care that is needed, the VA, as well, has been a leader in this country in providing such care to the individual veteran.

Aside from my own personal comments, PVA does appreciate this opportunity to comment on the implementation of the medical

care eligibility reform provisions, enacted last year through Public Law 99-272. The purpose of these reforms in PVA's view were not just to restructure or redefine VA health care eligibility based on means test at income levels, but to clarify the standards by which certain veterans can be assured of receiving their care based on a new entitlement.

From that standpoint, the intent of the law is to ensure that the VA must provide hospital care to service connected disabled veterans, certain veterans already receiving priority for health care under the old law and to lower income veterans, including the catastrophically disabled or chronically ill and medically indigent.

Those veterans not subject to the income eligibility assessment are entitled to care under certain guidelines.

PVA was seriously concerned about that in the past, as the Administration had attempted to circumvent eligibility requirements for Category C veterans by restricting funding to provide these services in its fiscal year 1988 budget proposal and by calling for a recision of already appropriated 1987 funds to accomplish the same purpose.

We would like to applaud this committee's action and support in restoring these funds to the VA, thereby rejecting a backdoor approach to circumvent the intent of Congress.

PVA is concerned in the meantime that no one is able to adequately assess what the changes in the law will mean, now or in the future in terms of VA workload and budget planning. This current uncertainty is due to several factors which are listed in our full statement.

We would point out, an expansion of Medicaid eligibility also proposed in the First Session of the 100th Congress could impact on the projected demand of the VA for acute care, as well as long-term services.

In PVA's opinion, neither the VA or other Federal Agencies are developing the data to fully assess the contribution of the veterans' health care system and providing a safety net for catastrophically medical services in the Nation today.

I would like to add our comments on nursing concerns. Mr. Chairman, on behalf of the members of the PVA, I would like to express an issue which is not only disconcerting, but complex, as well. There is the recurring problem of recruitment and retention of certain VA health care personnel. Shortages are nothing new, but it is different because rather than limited difficulties in recruiting and retaining nurses, the Department of Medicine and Surgery is now also experiencing the widespread shortage of respiratory, physical and occupational therapists, pharmacists and nurses.

These groups of professionals collectively provide most of the essential direct hands-on care to our Nation's veterans, and there is many reasons for this shortage—overtime, lack of educational opportunity, reimbursement for that educational pursuit, flexibility of work hours.

However that may be true, the unfortunate thing that is occurring around the Nation is that the private sector is looking to employ as many nurses and provide as many opportunities as they can, which are demonstrated in two pages of "Stars and Stripes" of April 13, which I am showing here and would hope that we could

enter in the record, that demonstrate the hiring practices outside the VA and the recruitment pursuits outside the VA, which are more than what the VA is providing at this time.

Mr. MONTGOMERY. Without objection.

Mr. DEGEORGE. It demonstrates higher pay and better working conditions. On that note, thank you for the extra time, Mr. Chairman, and I would conclude my statement at this time.

[The prepared statement of Mr. DeGeorge appears at p. 103.]

Mr. MONTGOMERY. Thank you, very much for your statement. Without objections, we will submit questions to the Panel, unless some Members of the committee do have questions. We do have one more panel and I would like to get to the vote on the bill. I know some of you have to go to other committees, and you have been here for over 2½ hours. Mr. Hammerschmidt?

Mr. HAMMERSCHMIDT. Thank you, Mr. Chairman. David, Jim, Frank and Dr. Mather, we not only thank you for your testimony, but we understand, as you do, that it is imperative that we have the views of your service organizations. We very much appreciate your being here and your submitting your testimony. We can submit questions for the record, in the interest of time. I want to thank all of you this morning.

Mr. DEGEORGE. Thank you.

Mr. MONTGOMERY. Tim.

Mr. PENNY. I, too, want to thank the service organizations for their testimony. In each case, they rightfully spend a lot of time in debating staffing levels and how to attract adequate staff, and how to address the issue of access to health care by our veteran population. But all of you in the concluding paragraph of your testimony mentioned support for the bill to increase per diem rates, and the importance that that places on quality health care for our aged veterans. I appreciate your testimony in support of that legislation, which, again, will be marked up at a committee meeting just following this hearing.

Thank you.

Mr. MONTGOMERY. Dr. Rowland.

Mr. ROWLAND OF GEORGIA. Thank you.

Mr. MONTGOMERY. Mr. Smith.

Mr. CHRISTOPHER SMITH. I join my colleagues in thanking the service organizations, also, and I appreciate your testimony as usual. Thank you.

Mr. MONTGOMERY. Thank you, Chris.

Panel II, Mr. James Bourie, of the AMVETS; Robert Lyngh of the American Legion, who will be accompanied by Phil Riggin of the American Legion, also.

Mr. Bourie, you may proceed.

STATEMENT OF JAMES BOURIE, NATIONAL SERVICE DIRECTOR, AMVETS

Mr. BOURIE. Thank you, Mr. Chairman. AMVETS appreciates the opportunity to express its views on the implementation of Public Law 99-272 and the status of recruiting and retention of certain VA medical health care personnel.

That provision obligates the VA to provide necessary hospital care and may provide nursing home care to nine categories of veterans and the establishment of means for veterans and other necessary items. Recent statistics released by the Agency indicate that of the nearly 1 million who applied for such medical care, just over 94 percent were either service-connected, or unable to pay for medical care.

We thus see a VA medical care constituency which is eligible for care as something the veteran community has long known and experienced. As far as we know, no VA medical center has set itself up to limit or treat one category of veterans as opposed to another.

Medical centers treat as space, resources and other factors permit. We are certainly aware of no instances of veterans being denied emergency care. Now, having some experience with it, our nationwide cadre of National Service Officers and VAVS volunteers do not report any significant problems with its implementation.

Having said that, we hasten to add our overall thoughts and observations on the means test. First, as more and more veterans seek VA medical care on an annual basis, we believe that more staff will be needed by medical administration to process the required paperwork.

We would also like to point out that the amount of dedicated funds coming back to the VA for care under the means test may fall short of projections, and that any funds being realized under the test are returned to the Treasury for deficit reduction and not to the VA to fund veterans programs as they should be.

Another medical care provision of P.L. 99-272 repeals the automatic eligibility for free hospital and nursing home care previously given to non-service connected veterans, 65 years of age and older. The VA needs to dramatically increase its nursing home construction and expansion programs.

On balance, Mr. Chairman, the revised medical care eligibility provisions are working with no known serious problem at this time. AMVETS, of course, objects to veterans having to pay for an earned right, but deeper than that, the payment of care to us certainly harbors more foreboding things for the VA.

The matter of recruiting and retention of certain VA health care personnel gives us equal pause for concern especially in the nursing care area. We believe the VA is indeed undergoing a nursing shortage. Low pay, competition from the private sector, few benefits, a revised Federal retirement plan, little opportunity for advancement and other factors not only preclude vital personnel from VA service, but also drive them out, interrupting service to veterans.

AMVETS believes legislative revision is in order to free the VA to identify necessary medical care professions, to develop recruitment plans and tools and develop retention plans.

We would now like to turn our attention to H.R. 1659 which would raise the per diem rates for payments by the VA to states for veterans' care. We applaud Mr. Penny and others for their genuine attempt to address this serious issue.

However, AMVETS feels that the amounts proposed in H.R. 1659 do not adequately cover the related costs of those services, and we

are in support of the National Association of State Veterans Homes' rates.

Mr. Chairman, that concludes our testimony.

[The prepared statement of Mr. Bourie appears at p. 110.]

Mr. MONTGOMERY. Thank you, very much. You are right to the point, and that is good. Mr. Lyngh, or Mr. Riggin.

STATEMENT OF ROBERT LYNGH, DIRECTOR, VETERANS AFFAIRS AND REHABILITATION, THE AMERICAN LEGION; ACCOMPANIED BY PHILIP E. RIGGIN, DIRECTOR, NATIONAL LEGISLATIVE COMMISSION

Mr. LYNGH. The American Legion appreciates, Mr. Chairman, the opportunity to appear before the subcommittee and present its views on implementation of the means test, and third-party reimbursement provisions of Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985, and the status of recruiting and retention of VA health care personnel, and a bill, H.R. 1659, that relates to State Veterans Homes.

We will first provide our perception of the means test and third-party reimbursement, which are now in the fourth quarter of the first full year of implementation. The means test implementation began on July 1, 1986, and third-party on October 1, 1986.

It is well known and not in need of elaboration that the American Legion did not agree with the necessity for the means test legislation. So far we do not see anything that has occurred since July 1 of last year that would cause our organization to change its views on this matter.

VA statistics for fiscal year 1987 developed through February 11, 1987, establish that of 931,312 veterans applying for care during the period, 94.1 percent were identified as being in Category A, 2.68 percent in Category B, and 2.3 percent in Category C, the latter being subject to the deductible and co-payment provisions of the Act.

In testimony submitted during consideration of the pending legislation, the Legion stated its conviction that the overwhelming majority of veterans applying for VA care were either service-connected or medically indigent. The above-quoted VA statistics clearly establishes that our estimation was in fact correct.

During consideration of the legislation, the Legion suggested as a first step, the completion by VA of an updated demographic profile of the VA patient population. We believed this might obviate the need for the legislation. Our suggestion was not accepted by the committees of the Congress, nor by the Veterans Administration. Now, curiously, VA has embarked on the development of just such a survey, through a procedure in association with the Bureau of the Census.

The planned survey will require about 2 years to complete and will adduce information, in addition to an updated patient profile. We agree with the need for the current survey, but wish it could have been done earlier.

When PL 99-272 was approved, the Legion stated that it would do all it could to assist in the implementation of the law. Recommendations to this effect were sent to all American Legion Service

Officers, and these service officers have done as much as possible to assist both veterans the Veterans Administration to implement the provisions of the law. All of us in the Legion will continue to do so.

The next issue under consideration is the shortage of personnel in important health care occupations in the Department of Medicine and Surgery. These positions include, but are not limited to nurses, pharmacists, physical therapists and occupational therapists.

The problem that now exists in the recruitment and retention of personnel in these occupations are certainly no great surprise to the American Legion. They have culminated for a number of reasons, some of which were avoidable and others that were not.

We have reviewed the draft report of the 1986 survey of health occupational staff, prepared by the Offices of Personnel and Labor Relations, and Information Management and Statistics of the VA's Department of Medicine and Surgery. The report contains a substantial amount of statistical data relating to shortages in the fields of registered nurses, licensed vocational nurses, nursing assistants, pharmacists, physical therapists, and occupational therapists.

However, statistics do not reveal the entire story. The VA's survey was completed in a 14-day period in December 1986, and covers a period October 1, 1985, through September 30, 1986. We have reviewed a number of our reports on site visits to VA medical centers, prepared by the Legion's National Field Representatives, between February 1985, and March 1987.

We have included excerpts from those reports and we commend them to the subcommittee's attention. Specifically, there are 35 station reports included in our statement.

We commend the subcommittee for its vigilance in placing this important problem on the agenda for today's hearing and thus making it an issue of badly needed discussion.

The third issue we have been asked to address is H.R. 1659. The American Legion strongly supports the proposed increases in per diem rates. Section 2 of the measure would amend Title 38, Chapter 81, by providing that the Administrator may award transition-year grants at any time after July 1, 1987. The grants for State Home construction would be awarded in the order of their priority on the transition-year list as established under PL 99–576.

The American Legion has no objection to this proposal. This concludes our oral presentation and once again, we thank the subcommittee for giving us the opportunity.

[The prepared statement of the American Legion appears at p. 117.]

Mr. MONTGOMERY. Thank you, Mr. Lyngh. Before we bring up the bill, are there any comments from my colleagues?

Mr. HAMMERSCHMIDT. Mr. Chairman, I, again, want to thank our witnesses from the service organizations for appearing before us. I regret that we still have this difference of opinion over the means test, as the position of the American Legion, but that is a fact that we have had for a long time.

I hope that their apprehensions are unduly great, but I guess time will tell on that. We do appreciate your statement here this morning.

Mr. MONTGOMERY. Dr. Rowland.

Mr. ROWLAND OF GEORGIA. Thank you for coming.

Mr. MONTGOMERY. There being no other comments, we appreciate your being here this morning.

[Whereupon, at 11:25 a.m., the hearing was concluded.]

APPENDIX

STATEMENT OF THE
HONORABLE G.V. (SONNY) MONTGOMERY
CHAIRMAN
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

THE SUBCOMMITTEE WILL COME TO ORDER.

TODAY THERE ARE THREE SUBJECTS OF OUR HEARING. TWO ARE CENTRAL TO THE MISSION OF THE VA'S DEPARTMENT OF MEDICINE AND SURGERY AND THE THIRD IS A VERY IMPORTANT COMPONENT OF THE ABILITY OF THE VA TO DELIVER EXTENDED CARE.

THE FIRST TOPIC IS THE IMPLEMENTATION OF THE ELIGIBILITY REFORMS UNDER PUBLIC LAW 99-272. LAST YEAR, IN RESPONSE TO A MAJOR INITIATIVE OF OUR COMMITTEE, THE CONGRESS PASSED WHAT I CONSIDER TO BE THE SINGLE MOST IMPORTANT PIECE OF LEGISLATION FOR VA MEDICAL CARE SINCE THE CREATION OF THE VA.

THAT LEGISLATION REDEFINED VETERANS' ELIGIBILITY FOR VA MEDICAL CARE. EVERY VETERAN WHO WAS PREVIOUSLY ELIGIBLE FOR VA MEDICAL CARE IS STILL ELIGIBLE.

HOWEVER, PUBLIC LAW 99-272 MADE A REQUIREMENT THAT HOSPITAL CARE BE PROVIDED TO A GROUP OF VETERANS THAT HAS COME TO BE TERMED "CATEGORY A".

THIS REQUIREMENT IS THE FIRST LEGISLATION EVER ENACTED INTO LAW THAT GAVE ANY VETERAN MORE THAN "SPACE AVAILABLE" ACCESS TO THE VA'S MEDICAL CARE SYSTEM.

THE REQUIREMENT WAS INTENDED TO GIVE VETERANS THE ABILITY TO PLAN FOR THEIR HEALTH CARE NEEDS; TO GIVE THE VA A REAL PLANNING BASIS FOR MANAGING VA MEDICAL SERVICES; AND TO GIVE THE CONGRESS A REAL PLANNING BASIS FOR FUNDING AND OVERSEEING THE VA'S DEPARTMENT OF MEDICINE AND SURGERY.

TODAY WE WOULD LIKE TO FIND OUT ABOUT THE IMPLEMENTATION OF THE ELIGIBILITY REFORMS AND THE RESULTS TO DATE.

THE SECOND TOPIC TODAY IS THE RECRUITMENT AND RETENTION OF HEALTH CARE PERSONNEL IN THE VA. THE HIGH QUALITY OF VA HEALTH CARE CAN BE ATTRIBUTED IN GREAT MEASURE TO THE WELL-TRAINED AND DEDICATED STAFF WHO ACTUALLY DELIVER CARE. ALL OF US ON THE COMMITTEE HAVE BEEN VERY CONCERNED TO HEAR OF SHORTAGES IN HEALTH CARE PERSONNEL IN THE VA.

EARLY THIS YEAR, THE COMMITTEE CONDUCTED A SURVEY OF THE PERSONNEL SITUATION IN VA MEDICAL FACILITIES. 150 MEDICAL CENTERS RESPONDED TO THE SURVEY.

OVERALL, NURSING VACANCIES AVERAGED 55 CALENDAR DAYS. PHARMACIST VACANCIES AVERAGED 102 CALENDAR DAYS. RESPIRATORY THERAPIST VACANCIES AVERAGED 47 DAYS, PHYSICAL THERAPIST VACANCIES AVERAGED 276 DAYS AND LICENSED PRACTICAL NURSE VACANCIES AVERAGED 57 DAYS.

THESE KINDS OF VACANCIES CAN ONLY HAVE A NEGATIVE EFFECT ON THE VA'S ABILITY TO DELIVER MEDICAL CARE. TODAY WE WOULD LIKE TO FIND WHAT THE VA HAS DONE TO ADDRESS THESE PROBLEMS.

THERE ARE SEVERAL AUTHORITIES THAT HAVE BEEN GRANTED TO THE VA TO HELP IN COMPETING WITH THE PRIVATE SECTOR FOR HEALTH CARE STAFF. THE USE OF THESE AUTHORITIES AND THEIR EFFECTIVENESS IN MEETING PERSONNEL PROBLEMS ALSO WILL BE EXPLORED TODAY.

THE THIRD TOPIC IS A BILL, H.R. 1659, THAT WOULD INCREASE THE PER DIEM REIMBURSEMENTS PAID TO STATE VETERANS HOMES FOR THE CARE OF VETERANS. IN ADDITION, THE BILL WOULD CLARIFY THE AUTHORITY OF THE VA TO AWARD GRANTS FOR STATE VETERANS HOMES DURING THE FOURTH QUARTER OF FISCAL YEAR 1987. THE STATE VETERANS HOME PROGRAM IS A CENTURY-LONG PARTNERSHIP BETWEEN STATES AND THE VA AND HAS PROVED TO BE A COST EFFECTIVE PROGRAM.

THE LAST TIME THE PER DIEM RATES WERE INCREASED WAS THREE YEARS AGO. THE PROPOSED INCREASE WOULD BRING THE VA PORTION OF THE TOTAL DAILY COST OF OPERATING STATE VETERANS HOMES TO 25 PERCENT.

AT THE CONCLUSION OF THE HERING WE WILL MARK UP H. R. 1659.

THERE IS A LARGE NUMBER OF WITNESSES WHO HAVE TAKEN THE TIME TO COME BEFORE US TODAY AND I WANT TO THANK THEM FOR THEIR DEDICATION TO VA MEDICAL CARE.

I WOULD NOW LIKE TO RECOGNIZE MY FRIEND JOHN PAUL HAMMERSCHMIDT WHO IS THE RANKING MINORITY MEMBER OF THIS SUBCOMMITTEE FOR ANY REMARKS HE MAY WISH TO MAKE.

REMARKS BY

HONORABLE JOHN PAUL HAMMERSCHMDIT

THANK YOU, MR. CHAIRMAN.

I AM PLEASED WE ARE TAKING THE TIME TODAY TO REVIEW PUBLIC LAW 99-272, THE VETERANS ELIGIBILITY REFORMS. THIS LEGISLATION MADE A FUNDAMENTAL CHANGE IN HOW ELIGIBILITY IS DETERMINED FOR VETERANS' HEALTH CARE BENEFITS. FOR THE FIRST TIME, THE CONGRESS CLEARLY PROVIDED FOR THE VETERANS WHO MOST NEED HEALTH CARE--SERVICE CONNECTED DISABLED VETERANS AND POOR VETERANS.

AS WE REVIEW THIS ACT, IT IS IMPORTANT TO KEEP IN MIND THAT THE ORIGINAL PURPOSE OF THIS LEGISLATION WAS TO PROVIDE BETTER AND MORE COST-EFFECTIVE HEALTH CARE TO OUR NATION'S VETERANS. PUBLIC LAW 99-272 WAS NEVER INTENDED TO BE USED, AND THE CONGRESS WILL NEVER TOLERATE IT BEING USED AS A TOOL TO LIMIT OR REDUCE THE LEVEL OF CARE PROVIDED TO OUR VETERANS.

MR. CHAIRMAN, OF ALL OF THE ISSUES FACING OUR SUBCOMMITTEE THIS YEAR, FEW ARE AS IMPORTANT TO THE CARE OF OUR VETERAN POPULATION AS THE RETENTION AND RECRUITMENT OF QUALIFIED HEALTH CARE PERSONNEL. THE VETERANS ADMINISTRATION, WITH THE SUPPORT OF CONGRESS, SHOULD AGGRESSIVELY ADDRESS THIS GROWING CRISIS.

WE MUST BEGIN BY MAKING SALARIES MORE COMPETITIVE WITH THOSE IN THE PRIVATE SECTOR. THE VA IS SIMPLY NOT GOING TO ATTRACT AND RETAIN HEALTH CARE PROFESSIONALS, ESPECIALLY NURSES AND PHARMACISTS, UNLESS SALARIES ARE MORE COMPETITIVE. IN THOSE AREAS OF THE COUNTRY WHERE THIS IS DIFFICULT, THE VA MAY WELL HAVE TO PROVIDE MORE FLEXIBLE WORKING SCHEDULES, CHILD CARE, AND TUITION REIMBURSEMENT. IN EFFECT, THE ENTIRE COMPENSATION PACKAGE WILL HAVE TO BE AS ATTRACTIVE AS THOSE OFFERED BY THE PRIVATE SECTOR WITH WHICH THE VA MUST COMPETE FOR QUALIFIED PROFESSIONALS.

STATEMENT OF

JOHN A GRONVALL, M.D.

CHIEF MEDICAL DIRECTOR

DEPARTMENT OF MEDICINE AND SURGERY

VETERANS ADMINISTRATION

BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

COMMITTEE ON VETERANS AFFAIRS

HOUSE OF REPRESENTATIVES

April 22, 1987

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to appear before your Subcomittee to discuss the recruitment and retention of health care personnel for the VA, our implementation of eligibility reform provisions of P.L. 99-272, and a proposed modification of the State home program.

RECRUITMENT AND RETENTION OF HEALTH CARE PERSONNEL

As a major provider of health care, the Veterans Administration must remain competitive as an employer of health care personnel. To assure the highest quality of health care as well as productivity and cost effectiveness, the providers -- the physicians, nurses, pharmacists, therapists, etc. -- must be highly skilled individuals. To attract and keep this kind of manpower, our employment system must be able to respond to the dynamic technological advances in health care.

These are conditions faced by all health care employers, but in the Veterans Administration we must also meld our employment of highly skilled professionals, technicians, and support personnel with the more complex requirements of public service employment processes. For this reason, we are often not able to immediately "capture" the candidate we want to hire.

I would like to take a few minutes to outline the conditions we are experiencing for some occupations in various locations, and actions under consideration to respond to these conditions, and to solve problems where they occur.

In an effort to improve our health care personnel management, we undertook a survey in December 1986 to determine the status of recruitment and retention for 16 health care occupations as of the end of FY 1986. This survey, along with information developed since that time, shows that we have significant localized recruitment and retention problems for Registered Nurses (RNs), Pharmacists, and Physical and Occupational Therapists. We are also concerned about potential difficulties in the radiologic and imaging science occupations and various technician positions.

The local problems we face in the recruitment area generally fall into the category of competition. Compensation levels are of primary importance, but to remain competitive employers offer a number of additional benefits such as tuition assistance, continuing educational opportunities, day care for children, paid health and life insurance, recruitment bonuses, less stressful work environments, weekends off or additional compensation for weekend work. Often the VA fares well in this competitive arena, but some times difficulties exist, particularly in urban areas with a concentration of health care providers.

In attempting to address this problem, the Department has intensified the Special Salary Rates Program. Special rates are authorized when they are considered necessary to make the VA more competitive (for the same occupational category) with the non-Federal labor market, to achieve adequate staffing, or to recruit personnel with specialized skills. As of February 13, 1987, the VA had 356 special salary rate authorizations in place covering approximately 9,700 employees. Of these authorizations, 92 covered RNs, 47 covered pharmacists, and 53 covered physical therapists. The special rates represent average increases varying by grade level over the regular rates of 7% - 19% for RNs; 5% - 19% for Pharmacists; and 4% - 21% for Physical Therapists. Special rate authorizations are estimated to cost approximately $36 million in FY 87, and we expect this amount to rise to approximately $50 million in FY 1988. Special rate requests for RNs, Pharmacists, and Physical Therapists receive priority consideration. As the Chief Medical Director, I can approve special rates for RNs, Physical Therapists and other Title 38 occupations. For Title 5 occupations, which includes pharmacists, we must notify the Director of the Office of Personnel Management 90 days in advance

of an intended new or increased special rate authorization. To date, the VA has typically experienced a 6-week review period before OPM concurrence is received; no authorizations have been turned down by OPM.

In addition to special rates, we have identified $2.5 million to be used in FY 1987 for tuition assistance specifically for those occupations and locations experiencing the most severe recruitment and retention problems. This would be in addition to the $4.5 million planned in FY 1988 for 240 Nursing scholarships. As a complement, we hope to expand the Scholarship Program in FY 1988 to include Physical Therapy. The FY 1988 Budget request includes $1.0 million planned for 55 scholarship awards for physical therapy students. We are convinced that expansion of the scholarship program would be beneficial to our recruitment and retention situation, and we appreciate your committee's endorsement of this funding in your budget recommendations. Experience has shown that we have a high success rate with the program as 73% of the full-time nursing participants have remained in the VA after completion of their obligated service requirement and 100% of the part-time participants have to date remained in the VA.

While these programs are helpful, it is apparent that more needs to be done. Currently, the Department has an active Task Force that is charged with studying recruitment and retention problems, and with identifying long-term solutions. The Task Force is considering such potential measures as:

- Improved benefits packages;
- Increased recruitment budgets;
- Expanded use of Saturday premium pay;
- Provision of recruitment bonuses for new hires;
- Streamlining the application process for Title 5 occupations, including the increased use of direct hire authority; and,
- Increased use of para-professional personnel.

Additionally, I will encourage the development of a national program to enhance the image of the VA as an employer. I believe we have been successful in informing the American public of our mission to provide the highest quality of health care to the nation's veterans. We now need to embark on a similar campaign to educate the health care professionals, and technicians, etc., both

in and out of the VA, about our system. We need to become highly visible in the "Employment Opportunities" section of newspapers and journals, particularly in the major metropolitan areas, and at job fairs. We need to let high school students, who are choosing colleges and possibly looking to health care careers, know about the VA as an employer. Such a campaign will require the expenditure of time and funds, but I believe that in the long-run, it, along with other changes, will solidify the VA's position as a national leader in health care employment.

P.L. 99-272 (ELIGIBILITY REFORM)

Public Law 99-272, "The Veterans Health Care Amendments of 1986" was signed by the President on April 7, 1986, and was implemented at all VA health care facilities on July 1, 1986.

The legislation established three categories of eligibility for VA health care -- Categories "A", "B", and "C". Category A includes all service-connected veterans, former Prisoners of War, other specially designated groups, and nonservice-connected veterans with incomes below $15,195 when single and $18,234 with one dependent. Category B consists of nonservice-connected veterans with an income between $15,195 and $20,260 when single and $18,234 through $25,325 with one dependent. Category C veterans are nonservice-connected veterans who have incomes in excess of the Category "B" amounts. Both Category "B" and Category "C" veterans are provided VA health care on a space-available basis, however, Category "C" veterans may be served only if they agree to make a co-payment to the VA.

During the first five months of this fiscal year, VA medical facilities processed 1,171,670 applications for care. The percentage of Category A applicants has been relatively constant at about 94 percent, Category B at three percent, and Category C applicants at about two percent. Nonveterans, such as active duty patients who are treated on the basis of a sharing agreement with DoD, and humanitarian cases, such as accident victims brought to the VA as the nearest source of care, comprise about one percent of applicants for care. The disposition of applications has been stable with 25 percent of applicants admitted to hospitals, 65 percent to outpatient care, with most of the remainder medically determined to not be in need of care. The attached table shows the disposition of all applications.

When compared to the same period last year, there has been a small reduction in the total number of applications (1,231,848 vs. 1,171,670). We believe that increased use by all VA medical centers of Decentralized Hospital Computer Program (DHCP) software to perform application functions may have resulted in counts of total applications which are slightly lower, but more accurate, than might have been reported in the past. We will be continuing to analyze changes in the number of applications and the mix of care provided to improve our understanding of the totality of care delivered by the VA system.

Means test DHCP software was developed and first distributed to VA medical centers in September 1986. The program allows computerized collection of income and asset information to determine the appropriate eligibility category. Additional means test computer software that will track services provided to veterans in eligibility Category C, and will compute copayments required of those veterans, was released to VA medical centers in March 1987. This system enhancement will allow identification of a veteran's eligibility category for each outpatient visit. For inpatients, the means test eligibility category has been recorded for all veterans discharged after October 1, 1986. The current system will provide valuable data regarding the use of patient services by the several categories of veterans.

During the first five months of FY 1987, the VA has collected $1,701,994 in Category C copayments and $1,956,002 remains outstanding. Most of the amount outstanding relates to patients still undergoing treatment.

H.R. 1659

Mr. Chairman, you also requested comments on a proposal (H.R. 1659) that would increase the per diem rates VA would pay to States for the care of veterans in State homes and would establish a mechanism for awarding State home grants during a so-called "transition period," beginning July 1, 1987. The amount payable for the domiciliary level of care would increase from $7.30 to $9.00, and a single rate of $20.35 would be payable for both hospital and nursing home care, up from $15.25 and $17.05 respectively.

The VA is required by Section 641(c) of Title 38, United States Code, to report to the Congress every three years regarding the adequacy of State home

per diem rates. The first report was submitted to Congress last fall. It stated that there are factors suggesting that per diem rates are adequate and others suggesting that increasing rates may be appropriate. The report concluded that some increase in per diem rates over the next five years may be appropriate. While an increase may be needed in the future, VA does not believe such an increase is necessary for FY 1988.

Section 2 of the bill would establish a mechanism for awarding State home grants between June 30, 1987, and October 1, 1987. Currently, grants are awarded on a "first come, first served" basis. Effective July 1, 1987, however, VA will replace this system with procedures established under Section 224 of Public Law 99-576 which requires prioritization of grant projects. Under these procedures, the Administrator will place each grant project on a priority list by July 1st of each year. The Administrator must then award grants during the next fiscal year in the order of their priority on the list. Section 224 did not, however, provide a mechanism for awarding grants between June 30, 1987, and October 1, 1987. Section 2 of H.R. 1659 would establish such a mechanism by giving the Administrator discretionary authority to award grants during this interim period. Such awards would have to be made in the order of their priority on one list to be established by July 1, 1987, in accordance with the newly developed procedures under Public law 99-576.

While we support enactment of a mechanism to permit the Administrator to award grants during this interim period, we believe that Section 2 fails to address an equity issue involving certain States with long-pending applications. The VA advised these States in October 1986, that grant funds would be available for their projects during fiscal year 1987. The States were advised that, in order to receive the grant, they had to complete all grant requirements before October 1, 1987, in accordance with current law. With this understanding, these States have incurred substantial costs in attempting to meet these requirements. Enactment of this proposal, however, would not permit the Administrator to award grants to these States unless they complete the grant requirements before July 1, 1987, or are high on the July 1, 1987, priority list. Some, therefore, may not be awarded a grant this fiscal year. In fact, some of them could conceivably lack sufficient priority under the priority procedures to ever be funded in the foreseeable future. In our view, the inequity that arises from the lack of an interim or transition period award procedure under Public Law 99-576 would not be resolved by this measure.

Instead, we recommend enactment of a draft bill which we recently transmitted to the Speaker of the House that would permit the Administrator to award a grant during this interim period if the VA has previously notified the State of the availability of funds for its grant. Of course, the State would have to meet all the statutory and regulatory requirements for the grant before October 1, 1987, to receive the grant. If the State does not meet the requirements before October 1, then none of the funds would be obligated for that project. The funds previously slated for that project would then become available only to projects which have been ranked through the new priority setting methodology.

We project that enactment of H.R. 1659 would result in increases associated with changing per diem rates of $15 million in the first fiscal year and $84.5 million over five fiscal years.

Mr. Chairman, this concludes my formal testimony. My colleagues and I will be pleased to respond to any questions that you or other members of the Subcommittee may have.

Attachment

VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE & SURGERY
VETERAN ELIGIBILITY AND THE FURNISHING OF HEALTH CARE
FISCAL YEAR 1987 THRU FEBRUARY 28, 1987

	VETERAN ELIGIBILITY	NUMBER OF APPLICATIONS A	CARE RECEIVED/SCHEDULED				MEDICAL EXAM.-NO FURTHER CARE REQUIRED F	CANCELED G	NOT ELIGIBLE H	TREATMENT MODALITY NOT AVAIL. I	REFER. TO OTHER FAC. J	PENDING END OF MONTH K	NOT AGREEING TO DEDUCT L	ITEM A AS % OF GRAND TOTAL M
			HOSP B	NURSING HOME CARE C	DOM. D	OUTP. CARE E								
	CATEGORY A SERVICE-CONNECTED													
01	100%	77,880	21,535	223	93	50,694	3,151	1,831	47	13	492	220		6.65
02	90%	2,948	622	306	3	2,125	126	59	5		106	12		.25
03	80%	7,722	1,882	144	10	5,222	337	223	23		13	40		.66
04	70%	16,232	4,157	23	75	10,847	656	431	100	3	646	115		1.39
05	60%	24,302	5,999	52	19	16,549	1,025	547	87	52	36	41		2.07
06	50%	36,182	7,380	74	74	25,771	1,393	811	99	1	59	99		3.09
07	TOTAL 50% THRU 100%	165,266	41,575	822	274	111,208	6,688	3,902	361	69	352	527		14.11
08	40%	31,163	6,720	52	47	22,081	1,608	645	92	2	51	42		2.66
09	30%	50,645	11,260	196	132	35,430	2,429	1,100	130	25	77	98		4.32
10	20%	44,577	9,108	98	180	32,118	2,177	973	197	15	84	81		3.80
11	10%	91,375	19,396	111	193	64,864	4,543	2,049	155	202	173	180		7.80
12	0%	86,096	19,677	161	477	59,497	4,133	1,780	198	31	124	118		7.35
13	OTHER S.C.	6,041	713	1		4,937	252	86	95		4	41		.52
14	TOTAL 0%-40% & OTHER S.C.	309,897	66,874	619	1,029	218,927	15,142	6,633	867	275	513	560		26.45
15	TOTAL (ITEMS 7 & 14)	475,163	108,449	1,441	1,303	330,135	21,830	10,535	1,228	344	1,865	1,087		40.55

4/20/87

VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE & SURGERY
VETERAN ELIGIBILITY AND THE FURNISHING OF HEALTH CARE
FISCAL YEAR 1987 THRU FEBRUARY 28, 1987

VETERAN ELIGIBILITY	NUMBER OF APPLI-CATIONS A	CARE RECEIVED/SCHEDULED HOSP B	NURS-ING HOME CARE C	DOM. D	OUTP. CARE E	MEDICAL EXAM.-NO FURTHER CARE REQUIRED F	CAN-CELED G	NOT ELI-GI-BLE H	TREAT-MENT MODAL-ITY NOT AVAIL. I	REFER TO OTHER FAC. J	PEND-ING END OF MONTH K	NOT A-GREE-ING TO DE-DUCT L	ITEM A AS % OF GRAND TOTAL M
16 FORMER PRISONERS OF WAR	6,335	1,655	24	13	4,178	308	124	4	5	38	7		.54
17 AGENT ORANGE/ IONIZING RAD.	18,050	4,125	4	40	12,280	1,069	472	28	2	26	61		1.54
18 WORLD WAR I	11,647	4,170	114	20	6,600	503	212	17	21	16	15		.99
19 VA PENSIONER	122,973	41,765	349	607	71,264	5,673	2,641	241	51	184	157		10.50
20 MEDICAID	12,765	4,097	189	18	9,567	1,421	285	66	3	14	12		1.09
21 OTHER N.S.C. CATEGORY A	454,543	17,206	921	1,382	296,995	24,903	12,300	1,098	245	940	866		38.79
22 TOTAL (ITEMS 16 THRU 21)	626,313	173,018	1,601	2,080	400,884	33,877	16,034	1,454	327	1,218	1,118		53.45
23 CATEGORY A TOTAL (ITEMS 15 & 22)	1,101,476	281,467	3,042	3,383	731,019	55,707	26,569	2,682	671	3,083	2,205		94.01
24 CATEGORY B OTHER N.S.C.	31,815	7,284	79	89	21,234	2,204	895	88	29	58	68		2.72
25 CATEGORY C OTHER N.S.C.	28,154	6,391	57	13	18,461	1,769	962	79	34	45	115	276	2.40
26 TOTAL CATE-GORIES A,B,C	1,161,445	295,142	3,178	3,485	770,714	59,680	28,426	2,849	734	3,186	2,388	276	99.13
27 ALL NON-VETERAN APPL.	10,225												.87
28 GRAND TOTAL	1,171,670	295,142	3,178	3,485	770,714	59,680	28,426	849	734	3,186	2,388	276	100.00
29 PERCENTAGE OF GRAND TOTAL	100.00	25.19	.27	.30	65.78	5.09	2.43	.24	.06	.27	.20	.02	

NOTE: COLUMN L IS FOR CATEGORY C ONLY.

4/20/87

NOVA
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Statement of
E. Elaine Lloyd, MS, RN, CS
President, Nurses Organization of the
Veterans Administration (NOVA)

Before the

U.S. House of Representatives Committee on Veterans Affairs
Subcommittee on Hospitals and Health
Hearing on the Status of Recruiting and Retention
of VA Health Care Personnel

April 22, 1987

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Mr. Chairman and Members of the Subcommittee, I am E. Elaine Lloyd, a Registered Nurse employed full-time as a Clinical Nurse Specialist at the Spinal Cord Injury Center, Veterans Administration Medical Center, Palo Alto, California. I am here today as President of the Nurses Organization of the Veterans Administration (NOVA) and I thank the Committee for the opportunity to appear before you. I am accompanied today by Noreen Sommer, RN, NOVA Legislative Director. While I speak as the representative of NOVA it is my goal to speak also to the need of Veteran patients for the nursing care provided by over 32,000 RNs in the 172 VA Hospitals and 200 outpatient clinics. This nursing care can be provided only when the VA is able to recruit and retain adequate numbers of Registered Nurses and other health care personnel. NOVA applauds you, Mr. Chairman, and the Committee, for the decision to hold this hearing on recruitment and retention.

Recruitment and retention of nurses in the VA must be viewed in the context of the changing scene of the supply of nurses. The Professional Nursing organizations as well as the public media have been reporting on today's shortage of nurses. The shortage today is caused in part by a decreased enrollment in schools of nursing with some schools reporting as much as a 30% drop in enrollment with the national average decline approximately 10%. Hospitals also lose nurses to expanding programs of home care, free standing clinics, and same-day surgery.

NOVA is concerned about the shortage of nurses and what that will mean to our nation's health care and particularly the Veteran patient. Registered nurses are the constants in the hospital--we are there 24 hours every day and seven days a week. We are the observers, the monitors, the teachers, the clinicians who collaborate with the physician and other health care professionals in the care and treatment of hospitalized veterans. With the historic low staff to patient ratios in the Veterans Administration Hospitals, nurses are already running at full speed.

Intravenous bottles and wound dressings can only be changed so quickly, basics such as turning a patient who cannot or does not move unaided or feeding a patient requires nursing time. Psychiatric patients who are a risk for suicide or are placed in restraints to prevent harm to themselves or others frequently require 1:1 nursing care or continuous or frequent observation. Patients can only learn to care for their colostomy or give their own insulin or be weaned from a ventilator at a pace that is safe. As nurses we believe the Veteran patient will get less than he deserves when there are less than adequate numbers of nurses to provide care.

The VA is currently not staffing to its own staffing methodology guidelines. Current estimates indicate the VA is from 4-8 thousand nurses short of what is required to operate the system. Any further loss of nursing staff is unthinkable when NOVA members throughout the country report

acute shortages of both RNs and LPNs in their own VA Hospitals.

Even when the shortages in personnel are not nurses, the Veteran is deprived of medical and nursing care. For example, when laboratory personnel cannot answer their phone until 11 a.m. due to personnel shortages, the physician and nurse are deprived of prompt information to treat the patient; when pharmacy personnel are not available to deliver medications the patient is deprived of nurses' time when the nurse must leave the patient care area to go to the pharmacy. As support services decline, nurses are often asked to fill in the gaps.

As the shortage of nurses in VA Hospitals increases, the patient to nurse ratio increases. Nurses are asked to work overtime and doubleshifts. Studies have shown over half of VA nurses work overtime about once a week. Overtime pay creates havoc with the budget. Nurses are further stressed when asked to work multiple shifts in the same week to fill in the gaps on top of their existing shift rotation which in itself is a disincentive in the VA. All of the above compounds the retention problem and VA nurses are lured to the private sector which can offer more stable work schedules, often without rotating shifts, better patient to nurse ratios, higher salaries and better fringe benefits including tuition reimbursement. "On call" pay for operating room nurses and others is higher in the private sector also.

The solution to these shortages is not forthcoming because, for the same reasons nurses are leaving, the VA is not competitive in recruiting RNs in the midst of a national shortage of nurses.

Shortages are nothing new. The widespread nursing shortages of the late 1970s and early 1980s had a severe impact on staffing in the VA Medical Centers. In August 1980 PL 96-330 called for the VA to conduct pilot programs and a study of actions that would enable the VA to recruit and retain sufficient qualified nursing personnel. 9,000 VA nurses responded to the survey--an overwhelming response. The data derived from the study supported the results of smaller studies made in the 1960s and 1970s in which demanding work schedules, inadequate staffing and a lack of opportunity for continuing education were seen as causes for dissatisfaction. Fortunately for the Congress and the VA, further study of VA nurses is not required at this time. The recommendations from the earlier study hold true today.

For your review I submit the fifteen recommendations emanating from the 1981 study:

1. Special salary rates and various pay options as provided for by PL 96-330 and PL 97-251 to enhance recruitment and retention should be monitored and adjusted in accordance with established criteria to assure that pay rates are competitive with but do not exceed the community rates.

2. Nurse staffing levels must be established and maintained in accordance with standards based on reliable measurements of workload.

3. Mechanisms must be provided to reduce job-related stress for nursing personnel.

4. The use of flexible work schedules, as provided for by PL 97-221 should be encouraged.

5. Support services must be consistently provided by personnel other than physicians and nursing staff.

6. Automated data processing should be utilized for applicable clinical and administrative functions.

7. Nurses' work assignments should be stabilized to minimize temporary reassignments to other patient care units.

8. Staffing patterns should be developed to eliminate rotation to different tours of duty.

9. Flexible work schedules should assure nursing personnel of every other weekend off duty.

10. Recruitment and retention of licensed pratical/vocational nurses should be stressed, in accordance with provisions of PL 98-160.

11. Tuition reimbursement should be offered to all nurses enrolled in courses which enhance their work.

12. Upward mobility programs for employees seeking nursing careers should be given additional monetary support.

13. Child care centers should only be considered if such a need is demonstrated since findings did not reveal that it was a major factor in recruitment and retention of nurses.

14. Funding for innovative projects to enhance recruitment and retention should be provided.

15. A national recognition program for nursing employees should be implemented.

Of these 15 recommendations modest gains have been made in many hospitals to minimize floating to other patient care

units, and the national recognition program for nursing employees has been implemented. But these modest gains do not correct the real problems of recruitment and retention of nurses. To stop the exodus of nurses from the VA and save the VA health care system corrective action must be taken.

The Veterans Administration deserves acknowledgement for the recent efforts of December 1986 to obtain data from all medical centers to assess recruitment and retention trends. The data reported was the recruitment and retention status as of September 30, 1986 and we all know that at that time the nursing shortage had not yet peaked.

The survey reports that "as a whole the Agency is maintaining adequate staffing levels," when in fact, 54.5% of all facilities reported a moderate to severe difficulty in recruitment and retention of Registered Nurses. Reflect for a moment on one California hospital reported as having only moderate difficulty in September that by November had closed 30 medical/surgical beds and 50 locked psychiatric beds. What has happened to the hospitals with serious and severe difficulty in recruitment and retention of Registered Nurses? Though numbers and percentages have a place in this discussion, what they do not address are the issues of errosion of morale when positions remain vacant for long periods of time and staff are asked to do more and more. The entire hospital system is further stressed by the

closing of critical care beds when there are not enough critical care nurses, but there are critically ill Veterans.

The agency in assessing recruitment and retention examined factors influencing the ability to attract and retain certain health professionals. NOVA is alarmed with the survey data on the private sector pay comparison. Only 54% of VA facilities report that salaries are comparable to or greater than those in local non-federal medical facilities. This is particularly disturbing in light of the fact that the congress has given authority to the VA to pay special salary rates to assure pay comparability. Presently 92 facilities use special salary rates to address the disparity between the VA and the community. NOVA believes the special rate may not be solving staffing problems because:

1. Staffing often needs to become desperate before facilities look at this option.
2. Approval to use the special rates may take 6-12 months.
3. Funding of the special rate must be provided by the facility.
4. The special rate may be in effect but not updated yearly and therefore does not remain comparable to the private sector.

These problems with the special pay rates may contribute to the survey finding that "50% of facilities

reported regularly scheduled general pay increases at other medical facilities in their areas placed them at a disadvantage in hiring and retaining Registered Nurses."

Additionally, 41.5% of the VAs report they are at a disadvantage in comparison to other facilities when it comes to paying weekend premium pay. This failure to be competitive in weekend premium pay is astonishing to NOVA as I am sure it is to you, Mr. Chairman, when the congress in PL 97-251 authorized the VA to institute the Baylor Plan and Saturday premium pay.

How can the VA be expected to solve its recruitment and retention problems unless pay comparability is closer to 100%? When 40% of those applicants who declined employment gave salary as the reason for declining, the VA should get the message. The VA should also get the message when job factors and working conditions accounted for an additional 33% of those who declined employment.

Lack of comparability in other fringe benefits places the VA at additional disadvantage. 77% of the VAs reported that they were at a disadvantage in competition with other facilities for RNs because others offered tuition reimbursement. In 1985 the American Hospital Association Survey found 70% of the hospitals they surveyed paid tuition reimbursement. Another fringe benefit lacking in the VA is employer paid Health Insurance, which 65% of VA facilities said placed them at a disadvantage.

To address this problem of recruitment and retention of nurses in the midst of a national shortage NOVA exhorts the VA and the Congress together to develop approaches to stop the hemorrhage of nurses from the VA and to infuse the system with new blood. There are critical steps that can be taken.

Salaries

VA salaries for nurses should be comparable to the private sector. The Special salary rates for RNs in effect in approximately 92 Medical Centers need to the budgeted and funded. The Medical Centers must be able to respond quickly to a changing market-place. Assuring that nurses on special salary rates also receive the Federal Employee Cost of Living Adjustment would prevent the severe discrepancies between the VA and the private sector.

The Saturday premium pay and the Baylor Plan option authorized by PL 97-251 must be used. Pay bonuses may need to be instituted to recruit and retain nurses.

Educational Support

A program of tuition reimbursement for VA staff to receive education and training while employed is necessary to help the VA compete with the private sector. Sabatical leaves of 3 to 6 months to allow indepth study would offer professional renewal to the career VA Registered Nurse and would benefit the institution in many ways.

Staffing and Job Factors

Steps must be taken to increase nursing staff to meet the increased workloads. There are staffing methods and methodologies to guide the VA to establish realistic workloads and they should be used. Staffing patterns to eliminate rotation of shifts must be developed.

NOVA requests this action on behalf of the competent and caring professional nurses working in the VA system who wish to continue with the mission of providing "care that will assist Veterans in maintaining or regaining health, learning to live with disabilities, or dying with dignity and comfort."

NATIONAL ASSOCIATION OF VA PHYSICIANS
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TESTIMONY OF

PAUL W. SCHAFER, M.D.

EXECUTIVE DIRECTOR

NATIONAL ASSOCIATION OF VA PHYSICIANS (NAVAP)

at the

HEARING REGARDING RECRUITMENT AND RETENTION

OF HEALTH CARE PERSONNEL

before the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE

of the

HOUSE COMMITTEE ON VETERANS AFFAIRS

APRIL 22, 1987

My name is Paul W. Schafer. I am a physician, a surgeon. I appear here today in a strictly unofficial capacity in respect to the Veterans' Administration but rather as the Executive Director of the National Association of VA Physicians (NAVAP). I speak on behalf of the Veterans Medical Program and those health care professionals who serve therein. I am a product of the surgical residency program of the University of Chicago where after a brief stint on that faculty I left to become Professor and Chairman of the Department of Surgery at the University of Kansas School of Medicine in Kansas City. There I was actively involved in our affiliation with five hospitals of the VA System; namely, in Leavenworth, Wichita, Excelsior Springs, Topeka, and Kansas City. I later served as Chief of Thoracic and Cardiovascular Surgery at the Walter Reed Medical Center and there trained a generation of the Army's surgeons who served with distinction in Korea and Vietnam. I now continue my service in the federal public sector as the full-time Chief of Thoracic Surgery at the Veterans Administration Medical Center here in Washington, DC. My current academic identification is as Professor of Surgery, Georgetown University.

Mr. Chairman I can attest that once there was a time after World War II in the late 40's early 50's when those of us charged with major health care responsibilities in the academic and private sectors actually despaired over our inability to match the monetary and other inducements offered by Veterans Administration hospitals as they were then able to hire away from us the best of the whole spectrum of health care providers and supporting personnel.

If the personnel pendulum could have then been said to have swung too far in favor of the VA hospital; it truly now can be said to have moved even farther in the other direction. We now are only able to recruit clerks, typists, secretaries, and administrative assistants of the most marginal competence. And to make matters worse, as soon as they acquire skills on the job we lose them to the far more attractive opportunities they can easily find elsewhere. And this observation extends to the other Title V employees who serve in our medical centers.

The situation becomes an outright disaster in respect to Title 38 personnel. The shortage of nurses is so acute that we are actually in the process of closing down whole wards and curtailing many essential functions. It is true that we are able to recruit young physicians just out of their residency training; but we can't keep

them. Many stay with us only long enough to study for their specialty board examinations. They quickly leave for what are perceived to be greener pastures soon after successfully obtaining their Board Certifications.

You can be sure that doctors, nurses, and other Title 38 personnel hear horror stories as to the way their predecessors have been treated. Why make a career commitment, become captive in the golden bonds of years of service, and then suffer a similar fate.

Not forgotten is the Holiday surprise of December 1981 when P.L. 97-72, without a grandfather provision, changed the formula for calculating annuity benefits. This took away tens of thousands of dollars from hundreds of nurses and doctors who in good faith had planned their entire professional lives on a set of retirement rules now cancelled retroactively over their entire careers.

Also not forgotten is the arbitrary and capricious 1982 decision by then-Administrator Nimmo to take away $5,000 of VA physicians' Special Pay. Though part of this loss has been recovered, each VA physician each year still loses $2,682. This irrationality cannot have a favorable impression on young VA doctors as they earn promotions only to find that they earn less. NAVAP tried without success to correct this anachronism in the courts. It is still possible of correction legislatively.

Morales among our health care workers is adversely effected by many other factors:

It is clear for all to see that the present Administration's attitude towards federal employees is less than that of a warm friendship.

Privatization of veterans health care is perceived by many as a real threat. And why not? We see McDonnell Douglas well on the way to taking over our data processing capability. Can the Hospital Corporation of America, National Medical Enterprises, or other giant corporate health-care-for-profit organizations be far behind?

Our health care delivery system may literally self-destruct under the weight of its own managerial and administrative burden, which has already grown to obscene proportions.

It does not go unnoticed that Agency leadership over the last few years has been somewhat less than stable. In the span of five years we have had three Administrators and three Chief Medical Directors. Each brings a new style, priorities, and management team. Thus we have had to cope with the changing emphases of MEDIPP and DRG-RAM and with other acronymed-programs on the horizons.

Many ask the question, "Where does the money go?". The Congress regularly appropriates veterans medical care funds in excess of the President's budget request and generally in the order of the Agency's identified current services requirements. Yet at the facility level we have inadequate supplies. And we are seeing sharp staff curtailment often orchestrated secretly and cynically by Byzantine cabals. We have just begun to function under a directive greatly curtailing beneficiary travel. This is a most cruel way to cut expenses. They see the 100 mile exemption as a penalty over which someone, somewhere must be gloating. It surely is not appreciated how many of our veteran outpatients will not be able to afford to come to our clinics.

But budget-driven cruelty can take many forms. Some of you may have seen one of its outrageous inhumane examples on last Friday night's television news. WUSA's J.C. Hayward reported the experience of a Salem, Oregon Vietnam veteran, Floyd Russell. Mr. Russell suffered a heart attack on March 27, 1986 and was taken 70 miles to the Portland VA Medical Center where he remained for seven days. The medication which his doctor prescribed for him on discharge regularly caused him to have symptoms from his GI tract mimicking those of his heart attack. He was told not to waste time making the 70 mile trip to Portland if he really thought he was having another heart attack, but instead to get to the nearest hospital as quickly as he could. Shortly thereafter he found himself in the Intensive Care Unit of the Salem Memorial Hospital where he incurred a hospital bill of $991.73. Mr. Russell tried to have the VA pay the bill but was refused on the grounds that his life had not been threatened. He has told me that he works at Salem's Capitol Bus Terminal where he makes about $10,000 per year. He offered to pay his hospital bill in installments but his offer was not accepted.

The Hospital turned the matter over to the Valley Credit Service, a collection agency, which promptly captured the family's $911 checking and savings accounts in the First Interstate Bank of Oregon.

Oh Yes, and for good measure they took his four-year old son's $18 savings.

Mr. Russell says he had good treatment by the Portland VA doctors and understands that the Veterans Administration just didn't have enough money to help him.

The Agency's quasi-military personnel system is itself a cause of much disenchantment. An individual quickly finds out how few rights one really has when the Agency itself is prosecutor, judge, and jury.

And, sadly it must be said, affiliated medical schools are again increasingly becoming too much involved in the hiring and firing of VA personnel and in the actual operation of VA hospital services. Professors, Department Chairmen, and Deans need be reminded that affiliation is an equal partnership.

If we are truly interested in first quality health care for our veterans I suggest the following actions be taken:

Discriminatory grandfathering differences between Title 38 and Title V annuity calculations must be eliminated.

The continuing $2,682 reduction in VA physicians Special Pay should be stopped.

The present Administration's attitude toward federal employees probably cannot be changed but the turning back of McDonnell Douglas's aggressive takeover efforts would send an appropriate message to America's health-care-for-profit corporate giants.

The Agency should be required to document the last decade's changing numbers of administrative personnel as compared to those of us who actually take care of patients.

The Agency's personnel practices and the complexities of affiliation need a complete overhaul.

Monetary and creative other inducements must be increased well beyond current levels. You only get what you pay for!

And why not get the answer to the question, "Where does the money go"? Is it diverted or wasted as it goes through the Central Office hierarchy, to Regions, to Districts, to Facilities, and finally to its only reason for being; namely, to take care of our veteran patients?

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

TESTIMONY

April 22, 1987

To The

Subcommittee on Hospitals and Health Care

on Veterans' Affairs

United States House of Representatives

Statement pertinent to H.R. 1659 to Amend Title 38, United States Code, to increase the per diem rates for payments by the Veterans Administration to States for domiciliary and nursing home care provided to veterans in State Homes, and for other purposes.

Prepared By:
Jack J. Dack, Chairman,
Legislative Committee
National Association of
State Veterans Homes
Commandant, Iowa Veterans Home
Marshalltown, Iowa 50158

Nations who engage in war have found that one of the inevitable costs of engaging in war is the care of those who were injured in combat or those who were disabled after combat. Such legacy dates back to the 16th Century in London and Paris. In America, the national government assumed responsibility for care of needy servicemen in the 1800's, particularly after the Civil War. A number of states, too, took steps to establish homes for the domiciliation of disabled soldiers and sailors. The State Homes were erected and operated entirely at state expense.

In 1888, the federal government established the first grant program in American history, thus appropriating funds to State Homes ($100 per year, per veteran) to assist them in their costs of providing care and treatment. Subsequent legislation increased the per annum rates and expanded the program in 1949 to include State Home hospital care.

In 1960, the method of federal aid payments to State Homes was changed from a per annum rate to a per diem rate by the passage of PL 86-625. A per diem rate of $2.50 was established in both domiciliary and hospital care. In 1964, PL 88-450 authorized the nursing home care program within the Veterans Administration, expanding the per diem program in State Homes to include a rate of $3.50 for nursing care. Again, subsequent legislation increased the per diem rates with the latest increase and present rates authorized by PL 98-160, effective April 1, 1984. The current State Home per diem rates are $7.30 for domiciliary care, $17.05, for nursing home care, and $15.25 for hospital care.

Much discussion over the years has evolved around what is the appropriate level of participation by the federal government or the adequate level of per diem payments to State Homes. In its report on the 1976 increase in per diem rates,

the Senate Committee on Veterans' Affairs stated that the increase would "keep the federal proportionate share of operating costs at levels consistent with the average federal proportionate share during the past five years, approximately 30%." In SER 98-1, Hearing before the Subcommittee on Hospitals and Health Care of the Committee on Veterans' Affairs, House of Representatives, Ninety-Eighth Congress, First Session, February 16, 1983, page 30, under Mr. Penny references a "historical standard" of established commitment to support the Homes. The federal participation in the cost of veterans' care in State Homes (1978-1986) has ranged from a high of 28% in 1978 to a low of 18.7% in Fiscal Year 1983. (Exhibit A, Copy of 1978-86 costs).

Title 38, U.S. Code, Section 641, amended by Public Law 98-160, Section 105, requires "the Administrator shall submit every three years to the Committees on Veteran Affairs of the Senate and the House of Representatives a report on the adequacy of the rates provided in Subsection (a) of Section 641 in light of projections over each of the following five years of the demand in the Veterans Administration for the provision of nursing home care to veterans eligible for such care under this Section and Sections 610 and 620 of this Title."

The initial report of June 30, 1986, received by the Committees deals only with the discussion of the nursing home care level of care. The State Homes are also involved in providing domiciliary and hospital type care. During Fiscal Year 86, the State Home program provided 4,679,406 days of care -- 1,570,713 domiciliary, 2,922,695 nursing home care, and 185,998 hospital days of care for an average of 12,891 veterans daily. (Exhibit B, FY 86 Report).

We in the National Association of State Veterans Homes are interested in the adequacy of the per diem rates for all three

levels of care. With this in mind, the National Association of State Veterans Homes developed a per diem proposal which was updated and forwarded to the Committees December 11, 1986, for consideration with rationale based on a thirty percent participation ratio.

We in the Association once again also strongly recommend the per diem rates for State Veterans Homes be reviewed and adjusted on an annual basis like the other Veterans Administration long-term care programs -- Community Contract Nursing Homes and funding for the Veterans Administration nursing home care programs. (Exhibit C).

It is felt this is a critical issue if states are going to continue to be a viable, cost-effective alternative to provision of long-term health care services for this nation's elderly veterans.

Published comments on the draft of the Executive Order, 1987 Budget, indicated a proposal calling for a "new long-term care policy," emphasizing the use of community nursing homes and State Veterans Homes rather than additional federal facilities. The State Home Program has for years proven itself a high quality, cost-effective alternative to the direct provision of care in federal facilities, a fact which the Executive Order in the Budget seemed to recognize. However, this recognition comes at a time with the ever-continuing rise in health care costs, when several state home facilities are dealing with hiring freezes, budget cuts and similar restrictive measures reflecting fiscal problems being encountered by many states. Continuation of the current per diem rate being reviewed every three years will be seen as a further disincentive to both the full operation of existing

state home facilities and the creation of the needed additional beds to accommodate the large and rapidly aging population of Word War II veterans now coming into our facilities in significant numbers.

H.R. 1659 introduced in the House of Representatives reflects specific per diem rates for which the Association is grateful and supports. We appreciate the continued interest and support by the Committee for the State Veterans Home Program.

Under Section 1,"PAYMENTS TO STATE HOMES", three rates are listed; however, in the title only nursing home care and domiciliary are mentioned. Under (b) EFFECTIVE DATE, once again only domiciliary and nursing home care furnished in State Homes are mentioned. The level of care, Hospital Care is omitted.

Such rates in the short run will increase the present federal per diem reimbursement participation. When analyzed compared with the projected average increase in the per diem costs within the State Veterans Home Program, a downward trend is noted following implementation. (Exhibit D).

We observe that all rates are well below the 30 percent target share. Further, the just published Veterans Administration "Guide for Inspection of State Veterans Homes: Domiciliary Care Standards," carries a strong potential for adverse impact on the cost of operations of many State Home domiciliaries.

It is important to note the role which the State Home Program plays in the overall scope of long-term care provided to veterans. The Veterans Administration nursing home units are increasingly focusing their efforts on the short-term rehabilitation of hospitalized veterans. Care in community contract homes is normally limited to a period of six months with some options for renewal. The care furnished by the state

veterans facilities is typically for severely disabled or impaired veterans who demonstrate a need for receiving nursing care over a protracted period of time, thus placing the state homes in the unique position of caring for severely debilitated patients requiring extensive amounts of care over a long-term period.

This has become increasingly noticeable with the advent of the Diagnosis Related Groups (DRG's) concept of providing care in community acute care facilities and recently implemented in the Veterans Administration Medical Centers. Without an adequate federal reimbursement structure for the states sponsoring State Veterans Homes, the expansion and/or full utilization of present capacity required for this long-term nursing care will not exist at that precise time in history when it is most critically needed.

In Section 2, "TRANSITION TO PRIORITY-LIST SYSTEM FOR STATE HOME CONSTRUCTION GRANTS," (b) Definitions, (2) defining "transition year list" appears unclear. Will the Administrator be granted the authority to award a grant for those FY 1987 projects that the Veterans Administration has notified of the availability of Federal Funds prior to July 1, 1987? Such projects would have been on the "first come, first serve" list. Would it not be more appropriate to delete the "definition of the transition year list (b2)" in the legislation and allow the Veterans Administration to determine the transition year list based on legislative requirements? It would be the list not now under the priority listing.

Thank you, Mr. Chairman and members of the Subcommittee for permitting the National Association of State Veterans Homes to present its views on this important legislation.

Jack J. Dack

Jack J. Dack, Chairman
Legislative Committee
National Association of
State Veterans Homes
Commandant, Iowa Veterans Home
Marshalltown, Iowa 50158
April, 1987

EXHIBIT A

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

State Veterans Homes
Domiciliary, Nursing Home and Hospital Care

Fiscal Year	Days of Care	Inflation Factor	Total Veteran Cost	Grant In Aid By V.A.	Percent of V.A. Participation
1978			$119,787,476	$33,650,314	28.09%
1979			$130,407,587	$34,690,318	26.60%
1980			$150,381,021	$35,210,938	23.41%
1981			$184,477,902	$40,743,234	22.09%
1982			$207,898,345	$41,616,923	20.02%
1983	4,359,648		$230,183,790	$43,185,424	18.76%
1984	4,554,179	8.25%	$260,951,051	$52,920,076	20.28%
1985	4,634,293	6.42%	$282,592,321	$63,154,842	22.35%
1986	4,679,406	7.17%	$305,789,146	$63,366,998	20.72%

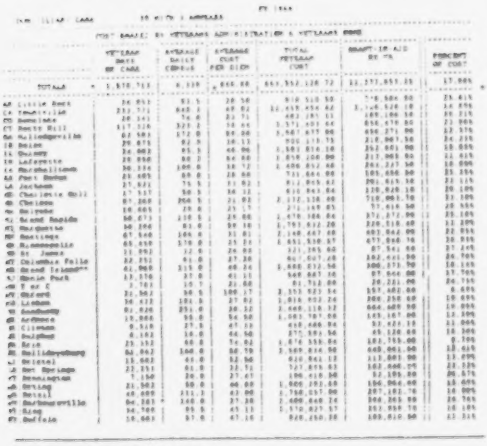
V.A. Federal Grants Applicable to Domiciliary, Nursing and Hospital Care provided by State Homes Office Assistant Chief Medical Director for Geriatrics and Extended Care, DM&S, Veterans Administration, Washington, D.C.

Unaudited totals

4/87

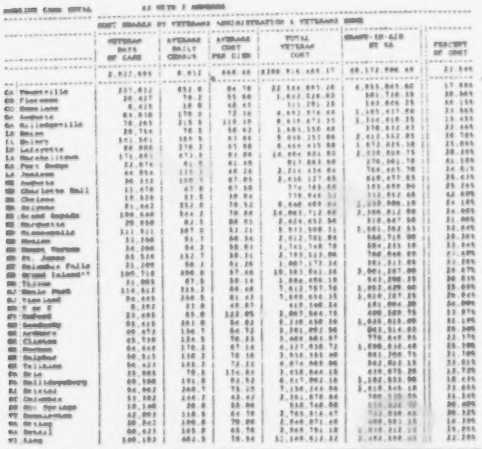
EXHIBIT B

VA FEDERAL GRANTS APPLICABLE TO DOMICILIARY, NURSING, AND HOSPITAL CARE PROVIDED BY STATE HOMES

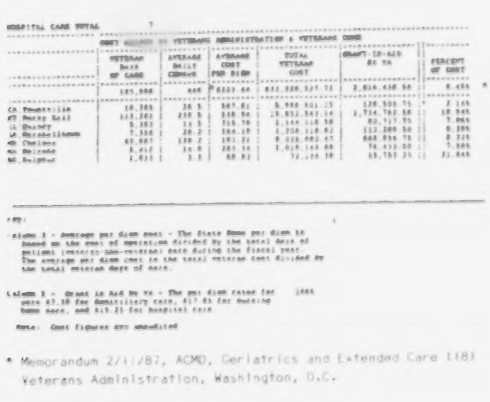


Corrected Average Cost Per Diem

* $ 48.46



* $ 71.48



* $179.14

* Memorandum 2/11/87, ACMD, Geriatrics and Extended Care (18) Veterans Administration, Washington, D.C.

EXHIBIT C

PATIENT OBLIGATION DATA

Activity	1986 Actual	1987 Budget	1987 Estimate	1988 Estimate	Increase(+) Decrease(-)
Average obligation/patient day:					
Medical bed sections.....	$316.91	$335.34	$345.04	$364.98	$+19.94
Surgical bed sections.....	415.43	428.17	455.50	486.01	+30.51
Psychiatric bed sections..	165.56	173.73	171.29	180.73	+ 9.44
Intermediate bed sections.	136.92	145.13	141.25	142.57	+ 1.32
VA hospitals.....	255.16	267.46	270.56	283.64	+13.08
VA nursing homes.....	118.24	120.04	123.90	134.51	+10.61
VA domiciliaries.....	47.16	46.11	49.78	53.75	+ 3.97
Contract hospitals.....	553.48	607.40	652.86	731.20	+78.34
Community nursing homes...	64.13	69.53	68.62	73.29	+ 4.67
State home domiciliaries 1/	7.30	7.30	7.30	7.30	...
State home nursing 1/.....	17.05	17.05	17.05	17.05	...
State home hospitals 1/...	15.25	15.25	15.25	15.25	...
Obligation/patient treated:					
Medical bed sections.....	$2,922	$3,160	$3,001	$3,137	$+ 136
Surgical bed sections.....	4,677	4,952	4,893	5,173	+ 280
Psychiatric bed sections..	5,281	5,798	5,060	5,255	+ 195
Intermediate bed sections.	13,543	14,606	13,311	13,281	- 30
VA hospitals.....	3,994	4,304	4,079	4,264	+ 185
VA nursing homes.....	18,897	21,561	20,556	21,780	+1,224
VA domiciliaries.....	7,492	7,865	8,259	8,940	+ 681
Contract hospitals.....	5,323	6,668	6,267	7,019	+ 752
Community nursing homes...	6,845	7,640	7,449	7,978	+ 529
State home domiciliaries..	1,510	1,371	1,371	1,373	+ 2
State home nursing.....	3,551	3,668	3,668	3,674	+ 6
State home hospitals.....	748	671	740	741	+ 1

1/ Reflect statutory per diems.

Veterans Administration, Medical Programs, Fiscal Year 1988
Office of Budget and Finance (Controller), Washington, D.C.

NATIONAL ASSOCIATION OF STATE VETERANS HOMES
PERCENTAGE ANALYSIS
of
PER DIEM INCREASE RECOMMENDATIONS

	FY1985-86 (1)	FY1986-87 (2)	FY1987-88 (2)	FY1988-89 (2)	FY1989-90 (2)
DOMICILIARY CARE:					
STATE HOMES AVERAGE PER DIEM COSTS:	$ 40.46	$ 42.81	$ 45.29	$ 47.92	$ 50.70
H.R.1659 RECOMMENDED V.A. PER DIEM REIMBURSEMENT RATE: (3)	$ 7.30	$ 7.30	$ 9.00	$ 9.00	$ 9.00
RECOMMENDED REIMBURSEMENT AS A PERCENTAGE OF AVERAGE PER DIEM:	18.04%	17.05%	19.87%	18.17%	17.75%
NURSING CARE:					
STATE HOMES AVERAGE PER DIEM COSTS:	$ 71.48	$ 75.63	$ 80.02	$ 84.66	$ 89.57
H.R.1659 RECOMMENDED V.A. PER DIEM REIMBURSEMENT RATE:	$ 17.05	$ 17.05	$ 20.35	$ 20.35	$ 20.35
RECOMMENDED REIMBURSEMENT AS A PERCENTAGE OF AVERAGE PER DIEM:	23.85%	22.54%	25.43%	24.04%	22.72%
HOSPITAL CARE:					
STATE HOMES AVERAGE PER DIEM COSTS:	$179.14	$189.53	$200.52	$212.15	$224.45
H.R.1659 RECOMMENDED V.A. PER DIEM REIMBURSEMENT RATE:	$ 15.25	$ 15.25	$ 20.35	$ 20.35	$ 20.35
RECOMMENDED REIMBURSEMENT AS A PERCENTAGE OF AVERAGE PER DIEM:	8.51%	8.05%	10.15%	9.59%	9.07%
NURSING - HOSPITAL CARE COMBINED: (4)					
STATE HOMES AVERAGE PER DIEM COSTS:	$ 77.92	$ 82.44	$ 87.22	$ 92.28	$ 97.63
H.R.1659 RECOMMENDED V.A. PER DIEM REIMBURSEMENT RATE:	N/A	N/A	$ 20.35	$ 20.35	$ 20.35
RECOMMENDED REIMBURSEMENT AS A PERCENTAGE OF AVERAGE PER DIEM:	N/A	N/A	23.33%	22.05%	20.84%

04-07-87

EXHIBIT D

NOTES TO THE
NATIONAL ASSOCIATION OF STATE VETERANS HOMES
PERCENTAGE ANALYSIS
of
PER DIEM INCREASE RECOMMENDATIONS

NOTE (1): Per Diem Costs for the Fiscal Year 1985-86 were extracted from the report; "Veterans Administration Federal Grants Applicable to Domiciliary, Nursing, and Hospital Care Provided by State Homes", Office of Extended Care (182), Department of Medicine and Surgery, Veterans Administration, Washington D.C.

NOTE (2): Per Diem Costs for all remaining years were projected based on an average annual increase of 5.8% as utilized by the Veterans Administration in it's report; "Adequacy of Per Diem Rates", 38 USC 641CC, June 30, 1986.

NOTE (3): Per Diem Reimbursements are actual for fiscal years 1985-86 and 1986-87. For fiscal years 1987-88, 1988-89, and 1989-90 they are as recommended in H.R.1659.

NOTE (4): The Per Diem Costs for Nursing - Hospital Care Combined were calculated based on the information provided in the reports noted in Notes 1 and 2.

JJD:rr

04-07-87

EXHIBIT D
(Page 2)

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS
April 22, 1987

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the more than 1.1 million members of the Disabled American Veterans and its Ladies' Auxiliary, I am pleased to appear here today to discuss various issues relating to the VA health care system.

Mr. Chairman, in your letter of invitation to testify, our views were solicited regarding the implementation of Public Law 99-272, the status of recruiting and retention of VA health care personnel and H.R. 1659.

Public Law 99-272

Mr. Chairman, Public Law 99-272 -- The Consolidated Omnibus Budget Reconciliation Act of 1985 -- contained provisions dramatically revising the criteria governing eligibility for receiving VA medical care.

Without question, this measure substantially improved the eligibility criteria for the furnishing of VA hospital (inpatient) care to certain veterans (Category A) by statutorily mandating that the VA shall provide such care to:

* veterans for a service connected disability;

* veterans whose discharge or release from the active military service was for a disability incurred or aggravated in the line of duty, for any disability;

* veterans disabled as a result of VA medical treatment or vocational rehabilitation (Section 351, Title 38, United States Code), for any disability;

* veterans rated 50% or more for service connected disability(ies), for any disability;

* veterans who have a service connected disability, for any disability;

* veterans who are former prisoners of war, for any disability;

* veterans exposed to certain herbicides (Agent Orange) or Ionizing Radiation, for any disability;

* veterans of the Spanish American War, Mexican Border Period or World War I, for any disability;

* nonservice-connected veterans who are determined unable to defray the expenses of necessary medical care.

Additionally, Public Law 99-272 established what is commonly referred to as a "means test." Under the provisions of the means test the VA may, to the extent resources and facilities are available, provide needed hospital and nursing

home care to nonservice-connected disabled veterans (Category B) with annual incomes above $15,195.00, but not to exceed $20,260.00, for single veterans and above $18,234.00, but not to exceed $25,325.00, for veterans with one dependent.

For those nonservice-connected disabled veterans (Category C) who are single and have incomes above $20,261.00, or veterans with one dependent whose incomes are above $25,326.00, the VA may also provide needed hospital or nursing home care providing the veteran agrees to make a co-payment of $520.00.

The remaining major feature of Public Law 99-272 pertaining to VA health care permits the VA to recover the reasonable costs of medical care provided to nonservice-connected disabled veterans by billing veterans' private health insurance companies.

As you know, Mr. Chairman, this authority, referred to as third party reimbursement, applies only to nonservice-connected disabled veterans and does not apply to any veteran who has a service connected disability.

Mr. Chairman, since the implementation of these VA health care reforms we are unaware of any significant problems that have been encountered with respect to veterans' eligibility for care or the actual provision of care.

Recently, we conducted a random telephone survey of a number of our National Service Offices in order to determine what, if any, specific difficulties or concerns have occurred in the agency's implementation of Public Law 99-272. Not surprisingly, the consensus opinion of our field offices is that a relatively smooth transition and implementation of these health care reforms has occurred since the effective date of the various provisions.

Mr. Chairman, this measure requires, in part, rather intricate reporting procedures to assess the effect of the implementation of this law. In this respect, we do have some concerns with the administrative procedures implemented to fulfill the reporting requirements. These concerns are fully outlined in Appendix B of the Veterans' Service Organizations Independent Budget Report which has been provided to all members of the Veterans' Affairs Committees. In our view, these concerns remain valid and unresolved.

Mr. Chairman, it is our opinion that the intent of Public Law 99-272 -- to provide VA health care services to service-connected and truly needy disabled veterans -- is being met in an adequate fashion.

Recruitment and Retention of VA Health Care Personnel

Mr. Chairman, it has been the long held belief of the DAV that the VA's Department of Medicine and Surgery does a commendable job of providing health care services to this nation's disabled veterans.

As vigorously as we hold to this belief and advocate the continuance of the system we, nevertheless, continue to be deeply concerned with the agency's ability to provide a sufficient number and mix of health care professionals to carry out the VA's mandated mission of providing quality and timely health care services.

Over the years, Mr. Chairman, much anecdotal information has been presented that points to rather dramatic problems within the agency concerning their ability to recruit and retain a sufficient number of qualified health care professionals necessary to maintain the viability of the system.

The VA operates a highly diversified medical care system which employs more health care professionals than any other single organization in the nation. While some agency-wide employment data on health care occupations is routinely maintained, comprehensive information concerning local staffing situations is not.

Recognizing this situation the VA conducted a survey of health occupational staff which was completed during January 1987.

The initial phase of this survey presented results for registered nurses, licensed practical nurses, nursing assistants, occupational therapists, physical therapists and pharmacists. The second and final report dealing with the remaining health care occupations is scheduled for completion and release within the very near future.

Mr. Chairman, this staffing survey revealed that the overall recruitment and retention situation for registered nurses, licensed practical nurses, occupational therapists, physical therapists and pharmacists was favorable for only about 47% of the VA's medical facilities.

The survey further revealed that 23% of the VA's facilities were experiencing moderate difficulty in recruitment and retention; 21.5% were experiencing serious difficulty; and 9% were experiencing severe difficulties in recruiting and retaining professionals within these occupations.

There were agency-wide net losses for occupational therapists, physical therapists and pharmacists and a very large net loss for nursing assistants. There were small net gains for licensed practical nurses (3%) and registered nurses (.7%).

Mr. Chairman, the survey findings and results are, in our opinion, comprehensive and forthright regarding the VA's recruitment and retention difficulties.

Following our review of the survey we have noted certain commonalities with reference to all of the occupations reviewed.

It becomes clear that the major problem areas of the agency's ability to retain these health care professionals are concentrated in the following areas;

* salary differentials;

* work load (patient to staff ratios);

* educational opportunities;

* family reasons; and

* necessity to relocate.

Mr. Chairman, in our view the major barriers identified in the VA's ability to retain qualified health care personnel can be resolved via various administrative and legislative remedies.

Specifically, we would recommend that the agency intensify it's efforts to:

* encourage and expeditiously act on requests for special salary rates for critical health care personnel;

* establish and maintain a sufficient number of health care personnel -- adequate patient to staff ratios in the nursing service -- as opposed to any decision to maintain less than the full time equivalent employees authorized and funded by Congress; and

* establish and implement a viable mechanism to assist employees who are required, for various reasons, to relocate to other geographical areas.

Additionally, we would suggest that the Subcommittee consider legislative action that would assist the VA in alleviating the identified disadvantages in both recruitment and retention by supporting action that would:

* provide tuition reimbursement for those pursuing degree programs;

* clarify the authority to provide a program of child care facilities;

* expand the authority for utilization of the Health Scholarship Program;

* provide employment opportunities under the authority of Title 38, United States Code, where appropriate; and

* provide pay differentials --"premium pay"--for working Saturdays.

Mr. Chairman, it is obvious that the VA, via the results of their own survey, is experiencing rather significant problems concerning the recruitment and retention of various health care personnel crucial to the provision of direct health care services to disabled veterans.

In recent months it has become painfully evident that these problems will become progressively worse, especially concerning registered nurses.

It is evident that the country is entering an era which will witness a crucial shortage of nurses entering and remaining in the work force. The reasons for this situation are many and varied. Simply stated, the VA's ability to employ qualified nurses is dependent, in large part, upon the availability of nurses in the private sector.

With fewer enrollees in nursing schools and the pool of qualified graduates continually declining, as well as competition for these qualified individuals being fierce, the VA's ability to recruit and retain nurses is being severely compromised. This situation will remain and may in fact worsen if current VA employment practices are allowed to continue unchanged.

Undoubtedly, comparable pay to the private sector is a major factor in attempting to remedy this situation. However, increased salaries may prove to be simply a short term solution.

In our view, actions must be initiated, as previously mentioned, that would allow the VA to at least keep pace with the private sector health care industry in the benefits and incentives offered to nurses that would make employment with the VA an attractive employment alternative.

It is our opinion that action is required immediately to provide a long term solution to the existing dis-incentives to employment in the VA's health care system. We would therefore encourage the agency and this Subcommittee to carefully consider the recommendations made herein.

H.R. 1659

As introduced, this measure would provide for increased per diem rates, payable by the Veterans Administration, to State homes for the provision of domiciliary, nursing home and hospital care to disabled veterans. Additionally, authority would be given that would allow the VA to award transition year construction grants at any time after July 1, 1987.

Mr Chairman, the DAV has long advocated support for the State Home Program and the benefits presented to the federal government, the states and disabled veterans. Therefore, we fully support adequate increases in the per diem payments as they represent, in our view, a continual commitment to provide cost effective health care services to disabled veterans.

Mr. Chairman, this concludes my testimony and I would again wish to thank you and the members of the Subcommittee for allowing us this opportunity to present our views regarding these most important issues.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

JAMES N. MAGILL, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

IMPLEMENTATION OF MEDICAL CARE ELIGIBILITY REFORM PROVISIONS AND THE RECRUITMENT AND RETENTION OF VA HEALTH CARE PERSONNEL

WASHINGTON, D. C. APRIL 22, 1987

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

Thank you for the privilege of appearing before this distinguished Subcommittee to present the views of the Veterans of Foreign Wars of the United States with respect to the Veterans Administration's implementation of the medical care eligibility reform provisions of Public Law 99-272; the status of recruiting and retention of VA health-care personnel; and, H.R. 1659. The VFW appreciates your holding this hearing which demonstrates your continuing concern for the health-care needs of our nation's veterans.

As you know, P.L. 99-272 made significant changes in the criteria used to establish eligibility for VA health care. Of major importance, the law also for the first time provides health care for certain veterans as an entitlement and not merely a benefit. Information available to us indicates approximately 97 percent of the veterans being treated in VA medical centers qualify for treatment as an entitlement. We have also been informed by the VA that since the

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implementation of P.L. 99-272, the number of veterans being denied treatment has been drastically reduced.

While the Veterans of Foreign Wars supported the "eligibility reform" approach advanced by the Congress, we also stressed the importance of having a sophisticated and valid reporting procedure to ensure that the full intent of the law was being carried out. The VA is devising a complex and comprehensive reporting procedure. As it is being fine-tuned, the VFW has been evaluating it and providing input to ensure that it is a useful tool.

The VFW already has suggested several refinements and posed some questions it believes will make the reporting procedure as accurate as possible. For example, the VA's earlier reporting form revealed some veterans were being turned away for "treatment modality not available." In a letter last December to the Administrator, the VFW challenged that entry by asking:

> "Are veterans now reported in that category left in frustration without care? What is their ultimate disposition?"

Those questions opened another area of VFW concern. Was there no accountability for, and were we losing the veteran eligible for care, who was turned away informally?

For another example, let's consider the veteran patient receiving acute care in a non-VA community hospital who now requires long-term care. His private physician calls a VA medical facility and is advised informally that no bed or treatment modality is available. We believe this may constitute denial of care if the veteran otherwise meets the eligibility requirements for care under the means test. Thus, in our December letter to the VA we asked: "Can we get a grip on those who may be informally turned away for lack of a bed or treatment modality?"

The VFW is pleased that the VA seems to be making every effort to help us and Congress judge the effectiveness of Public Law 99-272. The VFW will continue to do all it can to assist in this effort.

Mr. Chairman, we were also asked to comment on the recruitment and retention of VA health-care personnel. While it appears, for the most part, the recruitment and retention of VA physicians is at an acceptable level, there is a severe problem in the recruitment and retention of allied health-care personnel. Of this group, nurses and pharmacists are at a critical level. If the VA does not take steps to provide for the long-term solution to this problem, veterans' lives may be lost.

Of utmost importance, the VA must become competitive with the private sector in recruiting and retaining health-care personnel. Because the private sector is also witnessing shortages in selected professions, they are offering many attractive incentive programs. Of course, salary does play an important role; however, in-service training, work scheduling and transferability to name a few, are being heavily weighed by job applicants during the employment selection process. By carefully evaluating the total work environment and taking the appropriate action where indicated, the VA again can become competitive in recruiting and retaining health-care personnel.

As stated previously, salary at the entry level should be as competitive as possible within the industry. However, providing different salary levels in different parts of the county is not always possible for the government. Therefore, other incentives must be offered to attract high-quality health-care personnel. A scholarship program has proved extremely successful in the past and certainly could be expanded to professions other than just nursing.

Many health-care professionals are continually seeking education and this activity should be encouraged by the VA. By implementing quality in-service

training programs, the VA would not only be benefiting the employee but itself as well. Also, a tuition reimbursement program for the allied health-care professionals should be given serious consideration. These two steps alone, could be the catalyst for improving the recruitment and retention ratio.

It has been reported to the VFW that a high percentage of the loss of health-care personnel can be attributed to employees relocating due to a spouse being transferred to another section of the country. If the VA were to streamline its transfer program, many employees would probably not opt or be compelled to terminate employment. We envision a highly efficient system wherein an employee, when notified of a pending move, would contact the personnel office and job placement could be assured at another VA facility as close as possible to the new location.

Mr. Chairman, essential in retaining health-care personnel is the provision of the state-of-the art equipment and a modern physical plant in which to work. How many times has the VA been able to recruit personnel only to have them leave because of intolerable working conditions. Our field representatives report that automated data processing equipment is sorely needed in nursing station areas. Complaints are continually being registered as to nurses having to spend an inordinate amount of time performing clerical duties that are routinely handled by computer in the private sector.

Mr. Chairman, it has to be noted the VA is still feeling the impact of the Grace Commission's recommendation three years ago to reduce middle management in the federal government. While Title 38 health-care employees were exempted from this reduction, Title 5 employees (pharmacists, psychologists, lab technicians, etc.) were not. The VFW recommends any remaining Title 5 VA health-care employees be transferred to Title 38.

Mr. Chairman, the VFW strongly believes the VA must address their recruitment and retention problems with a long-term solution. The "quick-fix" simply will not work. What is particularly distressing is the fact that some of the same issues which precipitated the VA's problem in the 1970s appear to remain as the underlying cause of the dramatically worsening situation emerging today.

Finally, Mr. Chairman, the VFW in past testimony before this Subcommittee, has expressed its concern for the care and well being of our elderly veterans. The need for extended care by these veterans is increasing and will continue to do so well into the future. Inasmuch as a vast majority of the VA's nursing homes are filled to capacity, with most having long waiting lists for admission, it should not be difficult to recognize the important and crucial role State Veterans Homes play in providing quality care to our elderly veterans in a most cost-effective manner.

The VFW supports passage of H.R. 1659 which provides for an increase in per diem reimbursement rates to State Veterans Homes from $7.30 to $9.00 for domiciliary care, $17.05 to $20.35 for nursing home care, and $15.25 to $20.35 for hospital care.

This concludes my statement. Attached are VFW resolutions which are pertinent to this hearing.

Again, the VFW appreciates the opportunity to come before this distinguished Subcommittee to present our views. I will be happy to respond to any questions you may have.

Resolution No. 620

PHARMACY DEFICIENCIES

WHEREAS, the Department of Medicine and Surgery has endured reductions in GS 11-15 personnel as a result of mandates by the Office of Management and Budget; and

WHEREAS, this has severely impacted on the timely provision of pharmacy services to veterans; now, therefore

BE IT RESOLVED, by the 87th National Convention of the Veterans of Foreign Wars of the United States, that we petition the Administrator of Veterans Affairs to exempt pharmacy staff from further reductions in the GS 11-15 levels; and

BE IT FURTHER RESOLVED, that the Chief Medical Director be required to initiate a program to reduce the unacceptable waiting period by patients obtaining prescriptions from Veterans Administration facilities.

Adopted by the 87th National Convention of the Veterans of Foreign Wars of the United States, held in Minneapolis, Minnesota, August 15-22, 1986.

Resolution No. 620

Resolution No. 621

CONSTRUCTION PROGRAM

WHEREAS, cutbacks in the Veterans Administration Budget for Fiscal Year 1987 (FY-87) severely curtail both major and minor construction within the Department of Medicine and Surgery; and

WHEREAS, a great number of facilities are in need of extensive rehabilitation to refurbish and replace deteriorated basic medical care support equipment; now, therefore

BE IT RESOLVED, by the 87th National Convention of the Veterans of Foreign Wars of the United States, that we urge the Congress to allocate additional funds to the Veterans Administration health care budget necessary to provide replacement of essential equipment and provide modernization of aging facilities.

Adopted by the 87th National Convention of the Veterans of Foreign Wars of the United States, held in Minneapolis, Minnesota, August 15-22, 1986.

Resolution No. 621

Resolution No. 622

STAFFING REDUCTION IN VETERANS ADMINISTRATION HOSPITAL SYSTEM

WHEREAS, the present administration proposed a reduction of 8,848 medical personnel within the Veterans Administration's Department of Medicine and Surgery in Fiscal Year 1987, below the level mandated by Congress in Public Law 99-160, the HUD-Independent Agencies Appropriation Act of Fiscal Year 1986; and

WHEREAS, a reduction in health care personnel of this magnitude would seriously impair the Veterans Administration's capability to provide quality health care to the veteran; and

WHEREAS, the already targeted 1,900 personnel reduction under the one percent productivity improvement program proposed for 1986 in itself severely impedes VA medical care programs; and

WHEREAS, the Veterans Administration is already operating with a shortage of medical personnel in excess of 10,000 with productivity at 115 percent and with a 1,900 personnel reduction, productivity would be raised to 117 percent; and

WHEREAS, no hospital in the private sector could ever operate at such a high level of productivity over such a period of time without seriously endangering patient care; now, therefore

BE IT RESOLVED, by the 87th National Convention of the Veterans of Foreign Wars of the United States, that we oppose any reduction of medical care personnel within the Department of Medicine and Surgery of the Veterans Administration.

Adopted by the 87th National Convention of the Veterans of Foreign Wars of the United States, held in Minneapolis, Minnesota, August 15-22, 1986.

Resolution No. 622

Resolution No. 650

CONCERNING PER DIEM RATE FOR STATE VETERANS' HOMES, HOSPITALS AND DOMICILIARIES

WHEREAS, there are 45 state veterans' homes located in 33 states and the District of Columbia dedicated to the long-term care of disabled veterans who served honorably in the United States Armed Forces; and

WHEREAS, these veterans' homes and hospitals augment the Veterans Administration system of domiciliaries, nursing care facilities and hospital beds; and

WHEREAS, these state veterans' homes and hospitals do provide an important delivery of services to the veterans they serve and alleviate the necessity for the Veterans Administration to provide these types of services in the existing Veterans Administration hospitals and/or domiciliaries; and

WHEREAS, the various states have cooperated with the Veterans Administration to provide a uniformly high level of care for U.S. veterans in these state homes and hospitals and domiciliaries, the Federal Government through the Veterans Administration will reimburse state facilities at the following per diem rate:

Domiliciary Care	- 50% of the actual cost, not to exceed $ 7.30
Nursing Home Care	- 50% of the actual cost, not to exceed $17.05
Hospital Care	- 50% of the actual cost, not to exceed $15.25; a

WHEREAS, inflation has increased costs of the operation of state veterans' homes to a level far beyond costs prevailing when the above rates were established; and

WHEREAS, if the Federal Government fails to provide its fair share of the cost of care for veterans in state homes, it is not unlikely that states will be reluctant to provide for the increasing number of elderly veterans; and

WHEREAS, fair sharing of the cost of providing extended care for elderly veterans or disabled veterans will encourage states to meet the needs of the aging and disabled war veterans; and

WHEREAS, the Veterans Administration has estimated that the number of veterans requiring nursing home care is expected to increase steadily during the next 20 years, reaching over 270,000 (20%) being cared for through the Veterans Administration, state and contract community nursing homes; and

(continued)

Resolution No. 650 continued

WHEREAS, the Federal Government should reimburse the states for at least 50% of the actual cost of care provided in state homes, hospitals and domiciliaries - especially, now that the Veterans Administration requires homes, hospitals and domiciliaries to meet or exceed its own high standard; now, therefore

BE IT RESOLVED, by the 87th National Convention of the Veterans of Foreign Wars of the United States, that we seek legislation that will provide a more equitable cost sharing by the Federal Government.

Adopted by the 87th National Convention of the Veterans of Foreign Wars of the United States, held in Minneapolis, Minnesota, August 15-22, 1986.

Resolution No. 650

PARALYZED VETERANS
OF AMERICA

Forty Years of Service
1947-1987

STATEMENT OF
FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
OF THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING THE
IMPLEMENTATION OF THE MEDICAL CARE ELIGIBILITY REFORM
PROVISIONS OF PUBLIC LAW 99-272, AND THE STATUS OF
RECRUITMENT AND RETENTION OF HEALTH CARE PERSONNEL
APRIL 22, 1987

Mr. Chairman and Members of the Subcommittee, on behalf of the members of Paralyzed Veterans of America, I want to thank you for this opportunity to present our views regarding the implementation of Public Law 99-272, and the status of recruitment and retention of VA Health Care Personnel. Additionally, we have briefly stated our support for markup of H.R. 1659, to increase VA per diem rates for state domiciliary and nursing home care. I am accompanied by Dr. John Mather, Associate Executive Director of Medical and Research Affairs, and I am Frank R. DeGeorge, Associate Legislative Director. Mr. Chairman, we commend your efforts and purpose for this hearing this morning. We believe they are consistent with your efforts of the past.

PVA appreciates this opportunity to comment on the implementation of the medical care eligibility reform provisions enacted last year through Public Law 99-272. The Veterans' Health Care Amendments of 1986, signed by the President April 7, 1986, made major changes in a veterans' eligibility for VA health care. The purpose of these reforms, in PVA's view, was not just to restructure or redefine VA health care eligibility based on means-tested income levels, but to clarify the standards by which certain veterans can be assured of receiving that care based on a new entitlement. From that standpoint, the intent of the law is to insure that the VA must provide hospital care to service-connected disabled veterans, certain veterans already receiving priority for health care under the old law, and to lower income veterans including the catastrophically disabled or chronically ill, medically indigent. Those veterans not subject to the income-eligibility assessment and, therefore, entitled to care include: service-connected disabled veterans, former prisoners of war, veterans exposed to herbicides while serving in Vietnam, or veterans exposed to ionizing radiation, veterans receiving a VA pension, Spanish American War Veterans, World War I Veterans and veterans eligible for Medicaid.

For the balance of the nonservice-connected veteran population, the law created three categories based on a veteran's income. Within these three categories, the law also established new eligibility assessment procedures, based on income levels for determining whether nonservice-connected veterans are: (Category A) entitled to VA inpatient health care; (Category B) can receive that care on a space available basis, or (Category C) can receive care on a space-available basis, but only if the veteran agrees to pay a co-payment. With regard to this later category, PVA was seriously concerned by the Administration's attempts to circumvent eligibility requirements for Category C veterans by restricting funding to provide these services in its Fiscal Year 1988 budget proposal, and by calling for a recision of already appropriated 1987 funds to accomplish the same purpose. We would like to applaud this Committee's action and support in restoring those funds to the VA, thereby rejecting a back-door approach to circumvent the intent of Congress.

Under the old law, eligibility for inpatient care was restricted to veterans with service-connected disabilities, those other veterans in special categories mentioned above, veterans 65 and older, and other nonservice-connected veterans on a space available basis, who were loosely

determined by the VA as being unable to defray the cost of care. Estimates contained in the Independent Health Care Budget for Veterans, presented to the Congress by AMVETS, DAV, PVA and the VFW earlier this year indicate that under these old rules approximately 12 million veterans were eligible for some type of care and fewer than four million of them were included in the highest priority group. Many of these same veterans who had access to a VA hospital bed one year ago under the old law can receive care today. However, as an end result of Public Law 99-272, most of these veterans previously only eligible for inpatient care are now entitled to it. The VA is required to provide inpatient care to these veterans if they present themselves. No longer may they be denied care on the grounds that space is not available. As a result, today 13 million veterans are now entitled to inpatient care.

PVA is concerned that no one is able to adequately assess what these changes will mean, now or in the future, in terms of VA workload and budget planning. This current uncertainty is due to several factors:

1. Many veterans are as yet unaware of their newly acquired entitlement for VA care under Public Law 99-272, or the increasing out-of-pocket co-payments certain nonservice-connected veterans in higher income categories would have to pay.

2. While general public knowledge of these changes is growing, the private health care sector, non-VA hospitals, Medicaid and other state and local government health program managers are not fully aware of the new entitlements. As this awareness grows, they are likely to direct a growing stream of medically indigent and uninsured veterans to the VA rather than cover medical costs for these veterans with their own funds. At the same time, legislation currently before the Congress which would expand Medicare programs, limiting current deductibles and extending benefits for acute care catastrophic costs, if enacted, could temper VA demand to some degree.

   Similarly, an expansion of Medicaid eligibility also proposed in the First Session of the 100th Congress, could impact on the projected demand on the VA for acute care as well as long-term services. In PVA's opinion, neither the VA nor other federal agencies are developing the data to fully assess the contribution of the veterans' health care system in providing a safety net for catastrophic medical services in the nation today.
   Likewise, as the aging veteran and non-veteran population continues to grow, no one is looking clearly at the ever-changing mix and competition between VA health care programs and other public and private health care providers in order to determine adequate long-term health policy objectives. Obtaining the data to make this major assessment is mandatory in our view to properly measure and plan present and future VA demand and budget impact.

Means Test Reporting

PVA believes the current VA reports on means test implementation do not reflect the true volume nor the circumstances of denial of patient access to medical care. Last year, prior to the enactment of P.L. 99-272, information from the VA's own annual surveys indicated that between 22,000 and 30,000 veterans per month were being denied access to the VA system. And yet, according to the Chief Medical Director's recent testimony before the Congress, the new means test reporting system indicates that very few, if any, veterans are being turned away now even after the entitlement for services has been greatly expanded by the new eligibility rules. Certainly this enormous discrepancy indicates that either one or both reporting mechanisms are seriously flawed. For the purpose of budget planning or proper oversight, the Congress should insist upon the accuracy of the VA's reporting system.

With the inception of P.L. 99-272, Congress requested a report be developed to allow some assessment of the effect of the law. The attached table (Addendum A) is a copy of the report designed by the Agency to meet this requirement. Our review of the report leads us to conclude that it may not yield the information necessary to determine the full effect of P.L. 99-272 on workload.

It is important to understand that there is no clearly-defined relationship between an application for care and the actual care provided by the VA to a

given individual. For example, an applicant may apply for care and receive outpatient care, hospital care, nursing home care, and follow-up outpatient care and only complete one application. The agency-designed report deals only with applicants and their initial disposition within the VA health care system. Given that the report only addresses the initial disposition of an applicant for care, our specific concerns are as follows:

Column A - Number of Applications

Although this may represent an accurate count of applications completed by veterans, our discussions with medical center directors lead us to believe that there may be large numbers of telephone requests for care (transfer requests from other hospitals to the VA, etc.) that are not formally considered an application by the VA. Such requests may not be further processed because there is no formal application made by the veteran. To address this problem, we recommend that two additional columns be added to the report and provision be made for reporting the added information.

Column A.1 - Telephone Requests for Care

Number processed and reported as an application for care	Number not processed as an application for care

Column F - Not in Need of Care

Information reported in this item is of concern, because the label and description (as provided by the VA) of what to report is unclear. This may be seen from the glossary (Addendum B) that the VA has distributed for its form. Is the veteran's condition such that he was not ill enough to be given treatment "to obviate the need" for hospitalization or was he deemed to show a chronic stable condition that does not need immediate attention? We recommend an auxiliary report on the components of "not in need of care." The categories should include:

1. Minor medical problem treated at time of examination;
2. Chronic stable condition requiring no immediate follow-up;
3. Patient's condition does not now warrant hospitalization, but is ineligible for outpatient care.

Column G - Cancelled

The difference between veterans who "mail in applications and seek treatment at a private facility" and veterans who are not eligible for care reported in Column H is subtle. These two categories seem to overlap. Our recommendation is to have Column G represent applications cancelled because patients left the facility prior to medical examination to determine the need for care. Veterans who mail in application for care in a private facility should be counted in the not eligible category if in fact that is the case.

Columns I and J - Treatment Modality Not Available and Referred to Another VA Facility

The figures in these columns indicate that an application was made but the categories do not adequately track the actual disposition of that application. Did the veteran referred to another VA facility actually receive treatment at that facility, or was the veteran merely turned down for care at the first VA medical center only to be rejected or unable to obtain care at the next VA facility?

From the description of these two columns provided by the VA, the items should be combined and the column be treated in the following way:

Treatment Modality Not Available

Referred to Another VA Facility	Referred to Fee basis Care	Not Treated

We are concerned about the lack of consistency between data in this report and data collected via surveys of applications for care sponsored by the VA. The current reporting form should provide information on applicants

consistent with the VA survey. PVA would be willing to work with the agency to achieve this objective.

Outpatient Care for Category A Veterans

Under present law - Category A nonservice-connected veterans may also receive outpatient treatment when it obviates the need for impatient care, is a follow-up to an episode of inpatient care, or, according to the VA, "if space is available." There is considerable latitude in the exercise of the VA physician's judgment regarding the interpretation of "to obviate the need" for hospitalization. The recent marked reduction in VA inpatient census and length of stay is primarily dollar driven, stemming from the imposition of DRG-based resource distribution and decremental budgets. Similarly it appears that outpatient care to obviate the need for hospital admission is now more restrictively granted. PVA believes from the position of continuity of care as well as continuity with other federal health programs that outpatient services for Category A veterans should be made an entitlement.

Particularly for the chronically ill, medically indigent veteran with no service-connected disability, lack of clear access to outpatient services can be most unfortunate, if not dangerous. Such a patient may have need of ongoing close medical supervision only to be told that hospitalization is not necessary and therefore VA-furnished outpatient care is not available.

Couple this situation with the current restriction in beneficiary travel allowances, which will further limit a veterans physical access to a VA health care facility, and the potential for a medical crisis looms great, particularly for an older chronically ill veteran. The veteran is likely to have no other means of access to care unless he or she also qualifies for Medicaid. The Medicaid patient, incidentally, is provided ambulatory care regardless of inpatient care need -- an arrangement certainly more cost effective than inviting, through patient neglect, a crisis need of hospitalization. However, Medicaid is not an alternative for most indigent veterans under 65 because they do not meet its categorical eligibility requirements. If they are unable to access the VA system, these veterans are likely to add to the uncompensated care burden that providers are increasingly shunning or to fail entirely to obtain care when it is needed.

The VA health care system has always been distinguished for its offering certain patients a comprehensive, coordinated continuum of care. It is regrettable that P.L. 99-272 did not endorse that concept in the course of realignment of entitlement for Category A nonservice-connected veterans. Unrestricted outpatient care for all Category A veterans would not only make for a better quality of care, simplify administrative managment, encourage preventive care, reduce the incidence of acute complications, and -- in the last analysis -- better serve cost containment. Indeed the Congressional Budget Office, in the analysis of the original version of P.L. 99-272, which included full outpatient entitlment, judged it to be a cost saving legislative proposal. PVA commends the House Veterans Affairs Committee for including funding, $7 million, for Category A outpatient care and domiciliary entitlement in its FY 1988 budget recommendations. We would strongly endorse enacting legislation to achieve this goal.

Mr. Chairman, on behalf of the members of Paralyzed Veterans of America, I also would like to address an issue which is not only disconcerting, but complex as well. It is the recurrent problem of recruitment and retention of certain VA health care personnel. Shortages are nothing new. The widespread national nursing shortages of the late 1970's and early 1980's had a severe detrimental impact on staffing in VA Medical Centers (VAMC). The shortage we are experiencing today is different. It is different because, rather than limited difficulties in recruiting and retaining nurses, the Department of Medicine and Surgery is now also experiencing a widespread shortage of respiratory, physical and occupational therapists, pharmacists and nurses. These groups of professionals, collectively, provide most of the essential, direct hands-on-care to our nation's veterans. It is these groups who, in PVA's view, do much to determine the quality of care our veterans receive. While the nursing shortage of the late 70's and early 80's was quite perplexing, its negative impact for the VA was not nearly as ominous as the multidisciplinary health care personnel shortage we are faced with today.

The education and training of these professionals is based on a specialized, well-defined body of knowledge. Each has its own unique professional requirements which result in recruitment and retention problems specific to that profession. Therefore, it is clear to PVA that any general, sweeping

legislative proposal cannot address the individualized, specific needs of each of these professions. On the other hand, most individualized and specific legislative efforts will be criticized as a congressional attempt at micromanagement. PVA believes the only workable solutions will be conceived as a result of combined legislative and administrative initiatives; no single group can profess to hold the solution to this extensive and multidimensional problem. Rather, it is a resurgence of commitment which is needed. The combined commitment of Congress, the Agency, consumer groups, such as PVA, and the professionals themselves is necessary in order to engineer a variety of creative solutions which address both long-term and quick-fix results.

To PVA though, the issue is even more complex than mere retention and recruitment of licensed or certified health-care professionals. We contend that to surrender the care of this nation's veterans to anyone less than the finest caliber of personnel is a grave injustice. The issue then becomes further compounded as the VA enters the on-going, nationwide competition for the most discerning, quality-conscious professional applicants from a limited pool of resources. Stand-alone, quick-fix solutions simply will not work. They rarely do. The problem did not surface overnight, and it won't be solved in one day either. The health care field tends to attract humanitarian and altruistic professionals. Typically, these professional tend to believe that their job goals should be more rewarding than just their salary. PVA has enough familiarity with the care environment and has enough health professionals on staff to know that the average professional will put up with a lot of difficult conditions before calling it quits. The nurses, pharmacists, and therapists leaving the VA have experienced working short-staffed, with little or no support, excessive overtime and endured many weekend and off-shift tour of duty.

In reviewing the unsettling results found in the 1986 "Survey of Health Occupational Staff," who can blame them for looking elsewhere. And, who can blame potential VA applicants for choosing another place to work with VA morale at an all time low.

Some of the difficulties of these professions can be resolved with higher salaries; some with greater educational opportunities; and some with more career mobility. Each has its own unique needs, but one requirement all have in common is the need to know that the Administration and the Congress are committed to them and the maintenance of quality VA Health Care. Authorizing salaries which are lower than hospital main enance workers is not commitment, asking an employee to work so short-staffed that he or she is actually putting his/her professional license in jeopardy is not commitment, and, when an institution fails to reimburse or otherwise discourages its employees from continuing their professional education, it is the same as saying (we) do not have a vested interest in your future, (we) are indifferent toward your professional improvement; (we) are satisfied with the status-quo. PVA believes that when a health-care professional stops pursuing new knowledge, his or her professional growth stagnates. When any of these conditions exist, the quality of care received by the veteran is reduced and perhaps no one knows more acutely than our members, who have suffered a catastrophic injury, quality of care can mean the difference between life and death.

But before one can hope for a resurgence of commitment, PVA believes that the Administrator of Veterans' Affairs and the Chief Medical Director must recognize and acknowledge that a severe health professional shortage exists. Perhaps the results of the "Survey of Health Occupational Staff" will force this recognition. For too long now, we believe, the VA Central Office has been ignoring the fact that a problem even exists. For example, when questioned at a 1986 September Administrator/VSO meeting concerning staffing problems and shortages, the Chief Medical Director responded " . . . the only shortages are geographic nursing problems . . . " and when specifically asked about Physical Therapists, Occupational Therapists, Rehabilitation Therapists and Pharmacists, he reiterated his answer.

This year at the February 3rd hearing of the House Committee on Veterans' Affairs, the Administrator was asked a question regarding the shortage of VA Registered Nurses to which he replied, "Based on across-the-board data as recent as the last 60-90 days, we found that there is, overall, no nursing shortage."

It is this lack of commitment or cognizance on the part of an insensitive administration, compounded by public disinformation, general malaise, and "bottom-line" budget managers, who tend to make decisions in a vacuum, who cause the professional's cloak of dedication to begin to fray. The impact of

this issue needs to be magnified, not minimized, if a reasonable solution is to be realized. Even the glaring results of the Health Occupational Study were couched in language obviously meant to minimize the impact of the data. For example, the study, states "The staffing index shows that 45.5% of the facilities are experiencing favorable staffing conditions for registered nurses." What the study is really saying, although it never says it directly, is that 54.5% of all VA medical facilities are experiencing staffing conditions other than favorable. PVA believes that any staffing condition less than favorable, at the very least, results in a decrease in the quality of care received by veterans, if not resulting in conditions which are downright hazardous. The approach of the Veterans Administration must change.

In actuality, PVA did not come here today solely to hammer on the heads of administration officials, but, in fact, we want to offer our support in helping maintain the viability of health professions within the VA which appear to be endangered species.

The first suggestion we offer is for the Administration to allow hospital directors more flexibility in meeting their own geographical recruitment and retention problems. The complexity of recruitment and retention difficulties is enlarged by the variances which exist due to geographic locations. For instance, urban vs. rural/suburban hospitals. Directors need to be encouraged to use ingenuity and creativity in shaping policies to meet their own, unique needs. In this situation, it is difficult, if not unwise, to offer sweeping, generalized legislative remedies. We are talking about good-old morale boosting policies, such as one day off for the "Employee of the Month," allowing certain health professionals the flexibility to influence their schedule for their own hours and days off (within management parameters), offering substantial in-house educational opportunities, and other initiatives which offer solutions to distinct local problems.

Secondly, the administration needs to develop sound staffing guidelines which will result in a more appropriate number of authorized Full Time Equivalent Employees, and avoid the misrepresentation of numbers of professionals which has occurred in the past. PVA believes that staffing guidelines are so important and so necessary that the administration needs to prioritize this issue even if Congress must mandate VA officials to do so. For instance, a telephone survey done by the Office of Clinical Affairs, assessing the reliability of the number of authorized registered nurses, revealed a Registered Nurse authorized ceiling of 953 (for the 4 VAMC's surveyed). Staffing was actually expanded to 1,111 through the use of contract nursing personnel on the day of contract for a net discrepancy of 158 nurses. Authorized personnel were obviously inadequate to meet the needs of the VAMC's assessed. Low authorization is not cost-effective since contract personnel are generally more expensive than regular VA staff.

PVA, as an organization, does not have the expertise to offer specific solutions which will put the VA back as a competitive contender for high-quality professionals. We do know that as consumers of VA services we want to attract qualified professionals to the VA, and we want them to stay. Certain legislation does effectively help towards the achievement of this goal. Perhaps the single most needed piece of legislation is the Health Professional Scholarship Fund. PVA believes that not only should this program be expanded to other critically needed health professionals, such as Physical Therapists, as well as nurses, but that it should be fully funded this year, and then made permanent. If one single discrepancy exists between the VA and the private sector health-care providers, which is cited most often, it is the lack of educational opportunities and specifically tuition reimbursement programs provided by the VA. We commend the efforts of this Committee to reinstate this important program.

The Health Occupational Study demonstrated different problems in different geographical locations. We suggest that the VA maintain an advisory board comprised of regional directors to report to the Office of Personnel and Labor Relations. The recommendations of this Board should include reasonable administrative as well as legislative solutions to the issues of recruitment and retention. In addition, the CMD should respond, in writing, with the advice and consent of the Administrator, and describe his plans for the implementation of in-house solutions to problems in these areas.

PVA would like to reiterate that the gravity of this problem and its impact on quality of care necessitates its being placed as a high priority by DM&S.

PVA offers its support to the Congress, this Committee and the VA for whatever advice or assistance we may lend toward this common goal.

H.R. 1659

PVA supports H.R. 1659, which recognizes the need for an increase in the per diem rate by the Veterans Administration for veterans being cared for in State Veterans' Homes. The increase, the first in three years, would raise the daily Veterans Administration support for domiciliary residents from $7.30 to $9.00. The legislation would also combine the per diem rates paid for nursing home care and hospital care, currently at $17.05 and $15.25, respectively, to one increased rate of $20.35 per day for both. Thirty-five states have State Veterans' Homes, domiciliaries or hospitals which care for well over 17,000 veterans in Fiscal Year 1986.

Conclusion

Again, PVA appreciates the invitation to appear here today; we applaud the efforts of the Chairman and Members of this Subcommittee to address these issues, and, as well, the dedicated efforts of your staff. I will be happy to answer any questions that I can.

Statement of

James G. Bourie

National Service Director

AMVETS

Before The

Veterans Affairs Committee

Subcommittee on Hospitals and Health Care

U.S. House of Representatives

on

The Medical Reform Provisions of P.L. 99-272

Health Care

and the

Status of Recruiting and Retention of VA

Health Care Personnel

April 22, 1987

Mr. Chairman, and members of this Committee, the American Veterans of World War II, Korea and Vietnam (AMVETS) appreciates the opportunity to express its views on the implementation of the medical care eligibility reform provisions of P.L. 99-272 and the status of recruiting and retention of VA health care personnel.

Mr. Chairman, AMVETS is keenly aware that certain provisions of P.L. 99-272 had their genesis in deficit reduction. And that during deliberation there was tremendous pressure on all federal agencies to trim costs, reduce programs or to otherwise hold the budget line. The VA did not escape these pressures. Ways had to be designed to hold medical care costs while not sacrificing timely care; a most difficult and complex dilemma. If new and innovative ways were not implemented, then more drastic and far-reaching cuts would surely have fallen on the VA. In response to this situation, the Congress sought passage of P.L. 99-272, which in part, redefined eligibility for VA medical care.

To summarize, P.L. 99-272 obligates the VA to provide necessary hospital care and may provide nursing home care to nine categories of veterans; the establishment of a "Means Test" for those veterans who are unable to pay for care; repeals the automatic eligibility for free hospital and nursing home care for nonservice-connected veterans age 65 and older; and establishes what is known as third-party reimbursement which allows the VA to bill private insurers and others for the cost of care provided to veterans by the VA, but not service-connected veterans.

In extensive meetings, AMVETS voiced its strong disapproval of having veterans pay for VA medical treatment as it was, and is, an earned right through one's sacrifice and duty to country. Nonetheless, the momentum for these eligibility reforms were against us and in the end AMVETS, with other veterans service organizations, agreed to them as the least damaging alternatives for the VA and veteran programs.

As regards the so-called "Means Test", to elaborate somewhat, it only applies to nonservice-connected veterans with eligibility based on annual income. The VA may furnish care, if available, to nonservice-connected veterans with incomes not exceeding $15,000, not to exceed $20,000 for single veterans and $18,000, not to exceed $25,000 for veterans with one dependent (increased by $1,000 for each dependent). For care provided, the nonservice-connected veteran would pay, during any one year, about $492 for the first 90 days of care and about $246 for each succeeding 90 days of care. Based on income, veterans were grouped by category: Category A: $15,000 or less for single veteran or $18,000 or less for a veteran with one dependent; Category B: incomes above Category A, but below $20,000 for single veterans and $25,000 for a veteran with one dependent, and there are available resources to treat category B veterans; Category C veterans must agree to pay VA a deductible for care before they are eligible for that care.

Recent statistics released by the agency indicate that of the nearly one million veterans who have applied for medical care, just over 94 percent were either service-connected or category A, unable to pay for medical care. Category B comprised almost three percent and Category C comprised just over two percent. We thus see a VA medical care constituency which is either eligible for care due to their military service, or eligible for care because they cannot afford it. At least for the last category, something the veteran community has long known, that for the most part only the sickest and poorest of the veteran population are being treated.

Mr. Chairman, as far as we know, no VA Medical Center has set itself up to limit, or treat one category of veterans as opposed to another. Medical Centers treat as space, resources and other factors permit. And we are certainly aware of no instances of veterans being denied emergency care.

Now having some experiences with it, our nationwide cadre of National Service Officers and VAVS volunteers do not report any significant problems with its implementation.

Having said that, we hasten to add our overall thoughts and observations on the "Means Test". First, as more and more veterans seek VA medical care on an annual basis, we believe that more FTEE will be needed by medical administration to process the required paperwork. While we are now told that the average paperwork processing time is 10-15 minutes, we remain pessimistic that any steady rise in applicants will not necessitate additional medical administration staff at medical centers.

We would also like to point out that the amount of predicted funds coming back to the VA for care under the "Test" has fallen short of projections; and that any funds being realized under the "Test" are returned to the Treasury for deficit reduction and not to the VA to fund veteran programs, as they should be. Further, the "Means Test" data regularly made available by the VA reflects "treatment modality not available"; we are not at all certain what that means. The data also reflects a certain percentage of veterans "not in need of care." Are we to assume that veterans "not in need of care" received no care whatsoever; no exams; no follow-up exams; or were simply turned away? Another problem exists with military retirees seeking VA medical care. These retirees have the option of VA medical care, or, if eligible, Champus, or military medical care. However, once identified as military retired, they are sometimes turned away for VA medical care and asked to seek military medical care. We have also been informed by our National Service Officers that certain VA Medical Centers have stopped seeing nonservice-connected veterans for some treatment, like optometry. Whether these, and other situations are attributable to the "Means Test" remains to be seen.

Another medical care provision repeals the automatic eligibility for free hospital and nursing home care previously given to nonservice-connected veterans 65 years of age and older. AMVETS has perhaps heard more on this provision of the law than any other. With an acute shortage of state veteran nursing home beds and VA nursing home beds, we feel that the situation will only grow worse. Accordingly, the VA needs to dramatically increase its nursing home construction and expansion programs and there should be made available a greater amount for the state veteran nursing home program. With the aging veteran issue facing us, prudent action needs to be taken now.

A further revision of the medical care eligibility deals with the "third party reimbursement" provision allowing the VA to bill private insurers, or other health care carriers, for the cost of care given to veterans at VA facilities. The Administrator is to set the reasonable cost of care or services and that funds collected under this provision are to revert to the Treasury. Again, AMVETS strongly objects to veterans having to pay for an earned right. We also object that funds collected revert to the Treasury, why not at least to the VA; why make the veteran pay-off the deficit, the veteran did not create it. We would be most interested in knowing just how much has been collected under this and the "Means Test" provision and does it meet the expected return when the provisions were first proposed? We further understand that the insurance industry has actively opposed the "third party reimbursement" provision.

On balance, Mr. Chairman the revised medical care eligibility provisions are working with no known serious problems at this time. Again, AMVETS objects to veterans having to pay for an earned right, but deeper than that, the payment of care, to us, certainly harbors more foreboding things for the VA. We cannot believe that a healthy, viable, and robust VA medical

care system would allow veterans to pay for care or be ranked in order for treatment.

Mr. Chairman, the matter of recruiting and retention of VA health care personnel gives us equal pause for concern especially in the nursing care area. And notwithstanding pronouncements by the Department of Medicine and Surgery to the contrary, we believe the VA is indeed undergoing a nurse shortage. Our cadre of National Service Officers report an acute shortage of nurses at many Medical Centers. Low pay, competition from the private sector, few benefits, a revised federal retirement plan, little opportunity for advancement, and other factors not only preclude vital personnel from VA service, but also drive them out, interrupting service to veterans. To even pay bonuses, the VA must plow through a mass of checks and balances, regulations and other bureaucratic hassles.

Mr. Chairman, we cannot say with precision as to what other medical personnel are in short supply. It is something the VA does not make generally known and the definition of shortage, or retention is vague.

Nonetheless, AMVETS believes legislative revision is in order to free the VA to identify necessary medical care professions; to develop recruitment plans and tools and to develop retention plans. That the VA should be free to give bonus or other recruitment or retention stipends; provide advanced scholarships and to otherwise have at the agency's disposal a legislative "mix" of provisions, free of OMB or other restrictions, to attract and retain the best qualified medical health care personnel is absolutely essential to address the issue of shortages.

Health care personnel are unique and competition is keen. The VA must be given the necessary tools to compete in the highly competitive health care market.

Mr. Chairman, we now would like to turn our attention to H.R. 1659 which would amend title 38, U.S.C., Section 641(a) raising the per diem rates for payments by the VA to states for veteran care. The proposed amendment would raise domiciliary care to $9.00; nursing home care to $20.35 and hospital care to $20.35 also.

We applaud Mr. Penny and others for their genuine attempt to address this serious issue. However, AMVETS feels that the amounts proposed in H.R. 1659 do not adequately cover the related costs of those services. We, therefore, are supportive of the National Association of State Veteran Homes recommendation to raise the per diem rates to $25.40 for nursing home care; $14.37 for domiciliary care and $63.64 for hospital care. We must also agree with their rational for such increases: greater emphasis on state homes; state homes are a proven, cost efficient and quality program; current per diem rates are a disincentive; aging veteran population; growing cost of medical care and the VA's increasing focus on the use of state veteran facilities.

Mr. Chairman, AMVETS thanks you and the Committee for the opportunity to present its views.

Statement of

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and

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THE AMERICAN LEGION

before the

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

on

IMPLEMENTATION OF THIRD PARTY REIMBURSEMENT AND MEANS TEST, RECRUITMENT AND RETENTION OF VA HEALTH CARE PERSONNEL AND LEGISLATION TO INCREASE PER DIEM RATES FOR STATE DOMICILIARY AND NURSING HOME CARE

APRIL 22, 1987

STATEMENT OF ROBERT E. LYNGH, DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
April 22, 1987

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to appear before the Subcommittee and present its views on implementation of the Means Test and 3rd Party Reimbursement provisions of Public Law 99-272, the Consolidated Omnibus Budget Reconciliation Act of 1985; the status of recruiting and retention of VA health care personnel; and a bill, H.R. 1659, that relates to State Veterans Homes. The pertinent provisions of PL 99-272 are encompassed in Title XIX of the Act.

We will first provide our perception of the Means Test and 3rd Party Reimbursement, which are now in the fourth quarter of the first full year of implementation (Means Test implementation began on July 1, 1986 and 3rd Party on October 1, 1986).

As a first small point, may we observe that The American Legion does not like to see the word "reform" used in describing the Means Test. The word implies there was something in earlier eligibility provisions that needed reform. This is not the case. We prefer to refer to the changes as modifications of veterans eligibility for VA health care.

It is well known and not in need of elaboration that The American Legion did not agree with the necessity for the Means Test legislation. So far we do not see anything that has occurred since July 1 of last year that would cause our organization to change its views of this matter.

VA statistics for Fiscal Year 1987, developed through February 11, 1987, establish that of 931,312 veterans applying for care during the stated period, 94.1% were identified as being in Category A, 2.68% in Category B, and 2.38% in Category C, the latter being subject to the deductible and co-pay provisions of the Act. In testimony submitted during consideration of the pending legislation, the Legion stated its conviction that the overwhelming majority of veterans applying for VA care were either service-connected or medically indigent. The above-quoted VA statistics clearly establish that our estimation was correct.

During consideration of the legislation the Legion suggested as a first step, the completion by VA of an updated demographic profile of the VA patient population. We believed this might obviate the need for the legislation. Our suggestion was not accepted by the Committees of the Congress, nor by VA. Now, curiously, VA has embarked on the development of just such a survey, through a procedure in association with the Bureau of the Census. The planned survey will require about 2 years to complete, and will adduce information in addition to an updated patient profile. We agree with the need for the current survey, but wish it could have been done earlier.

When PL 99-272 was approved, the Legion stated that it would do all it could to assist in the implementation of the law. Recommendations to this effect were sent to all American Legion Service Officers, and these Service Officers, have done as much as possible to assist both veterans and VA to implement the provisions of the law. All of us in the Legion will continue to do so.

Additionally, the National Organization developed a questionnaire to be used by our Field Representatives in their VA health care facility surveys in an effort to monitor the implementation of the law. The questionnaire comprises 34 specific questions directed to VA facility staff. The questionnaire was first used at 5 stations in November, 1986. Results were inconclusive due to the brevity of experience at that time. In February and March of this year, 7 stations have been surveyed. The results indicate that problems so far appear to be for the most part restricted to the Administrative Services of the stations. More paper work; more man-hours of work; back-up of paper work; extension of processing times for applicants; and still some confusion among administrative personnel as to the correct processing methods. All of these are to be expected with new procedures impacting such a large system. No doubt many of the problems will be smoothed out in time. One large station has not thoroughly followed the new procedures due to the extremely heavy case load impacting the admitting areas. Billing so far appears to be spotty, and collections equally so. As yet there appear to be no standardized procedures for collections, which are the responsibility of station Fiscal

Services. Assistance in the form of guidance from Central Office is reported as good, though even Central Office is still working out and refining procedures. Computerization of many stations has been helpful in processing of paper work and record-keeping. Patient acceptance of additional paper work has been generally good. Extended admitting times have definitely impacted service-connected as well as nonservice-connected veterans because the service-connected get tangled up in the waiting lines for service.

Delivery of care has not been noticeably affected from the standpoint of the clinical staff, which provides care to all who are passed through from the administrative to the clinical services of the facilities.

So far, in the limited number of stations surveyed in the early months of this year, there appears to be a feeling among VA staff that the added paper work may be needlessly burdensome and is not accomplishing anything significant, since the over-whelming majority of veteran applicants are in Category A, and thus entitled to care on a categorical basis. As with The American Legion, many VA staff already knew that. Perhaps nobody asked their opinion. Admittedly, more experience has to be gained before any attempt at conclusions is made.

The questionnaire we have developed may have to be modified as our own Representatives gain experience in identifying pressure spots and potential trouble spots in the admitting procedures. We will monitor that and make adjustments as necessary. And we will, most assuredly be happy to share the information we develop with the Committees of Congress, as well as with the VA.

There is one possible problem that was raised during our recent Washington Conference of all our Service Officers. It is whether veterans are being properly advised by VA personnel to include unreimbursed medical expenses on Form 10-10f. The point being that medical indigency is being established on the same basis as is entitlement to pension under provisions of PL 95-588. Unreimbursed medical expenses, properly reported could place some veterans in Category A, as against their being placed in Category B. We are going to ask the Department of Medicine and Surgery to make sure that eligibility clerks are familiar with this provision of the pension law. We believe that at least some of them are not so familiar at present.

With reference to 3rd Party Reimbursement, our data, so far indicates, as we expected, that very few veterans approaching VA for care have health insurance. Billings and collections have been minimal at the stations we have surveyed. Insurance carriers do not seem to be in any hurry to remit. And Fiscal Services at the busiest facilities are not treating 3rd Party billings as a priority (bearing in mind that all administrative services at health care facilities are very busy with priority business). It is a given in the health care field that medical care facilities generate great amounts of paper work. And since recoveries go to the Treasury rather than to the facility, we can understand that VA personnel feel no over-whelming need to hasten the 3rd Party billing and recovery process.

As experience develops, we believe it will become clear that if these procedures are to be followed thoroughly, more personnel is going to have to be provided to avoid paper work congestion that will inevitably impact delivery of care. The administrative operations cannot be separated from the clinical as all VA, and indeed non-VA health care facilities are organized. More personnel means greater overhead cost, which will affect the cost-effectiveness of the new procedures. And if overhead cost escalates without any appreciable effect on case loads, or without significant increases in recoveries to offset the added costs, then at some point an evaluation should be made as to the wisdom of maintaining an elaborate administrative mechanism that is doing nothing more than accumulating paper.

With reference to the absolute entitlement of Category A applicants to needed care, we have alerted our Service Officers to watch for instances where needed care is not provided. Our present expectation is that if instances do develop they may be in the area of reimbursement for unauthorized expenses; such as patients referred to non-VA facilities by VA facilities for one reason or another, and where the veteran then expects VA to pay for costs incurred. If this happens it will touch on the disagreement that developed last year, between the VA General Counsel and this Committee, as to what authority VA has to pay for needed care provided to nonservice-connected veterans by non-VA facilities. If The American Legion encounters cases of this kind it plans to assist the veteran to use all administrative procedures provided to recover costs incurred. If problems in individual cases end up being unresolveable we will bring them to the attention of the Committee.

Before concluding this portion of this statement by expressing again the fundamental reasons The American Legion does not agree with the Means Test and 3rd Party Reimbursement, we will say there has been a gain through the new legislation in establishing the absolute entitlement of certain categories of veterans to VA care. We refer to such groups as former POWs, Agent Orange and radiation victims, and the other groups included in Category A by definition. We believe this desirable goal could have been achieved otherwise than by enactment of PL 99-272.

One of the things the Legion said last year, when the Means Test legislation was being considered, was that if enacted, the Administration could be expected to make another move to restrict eligibility. Sure enough, in its first Budget Message following enactment of PL 99-272, the Administration included a rescission request for $75 million, to reduce care to Category C veterans. Fortunately, the Committees have not accepted this proposal. Our objection to the proposal stemmed from two considerations. First, it would be patently impossible to remove $75 million from current appropriations without immediately impacting ability of VA facilities to provide full care for Category A applicants - which include the service disabled. And second, any further reduction of eligibility would, in our judgment assuredly lead to efforts to ultimately restrict eligibility to job-related conditions - an idea that has been voiced in the Congress before this. The basic point here is that once the door to the eligibility criteria has been opened there will, we believe, be no cessation of efforts to continue to restrict it until the VA system is reduced to a fragmentary program designed to care for traumatic injuries.

Which brings us to a brief restatement of The American Legion's position. We believe the VA health care program is used over-whelmingly by two categories of veterans - the service disabled and the medically indigent. Most veterans always have and will continue to provide for their own health care. There are a number of reasons for this, only one of which is financial. Another is the fact that most people, when they are sick, prefer to seek care in the immediate area of where they live. That is what most veterans do. Statistics so far developed since July 1, established the truth of our belief, in our opinion. The small number of veterans with resources who seek VA care - less than 3% - could be encouraged to seek care elsewhere through means other than legislation changing the entire nature of the present VA system. The VA health care system is simply <u>not</u> overburdened with rich veterans. All the paper work that is being generated is proving nothing. It has not and will not, we believe affect the case load of the VA system.

The danger that has been created by this legislation is that those who do not approve of the very existence of the VA health care system can now say that since it is an almost identical collateral of the Medicare-Medicaid program, why not meld the two programs, with perhaps an absolute priority for care for the service-disabled. Cost savings will be the principal argument put forth to achieve this goal.

We know very well that the friends of veterans in Congress, which includes all the members of the Veterans Affairs Committees of the House and Senate, do not intend to let this happen. But The American Legion is not totally reassured by this fact because those who oppose the existence of the present VA health care program are powerful organizations. What they lack in numbers, as compared to the veterans organizations they make up in resources the veterans organizations do not have.

As we complete the first full year of experience with the modified eligibility requirements created by Public Law 99-272, The American Legion is constrained to say to the Committee that it is, - to say the least - apprehensive as to the future of veterans health care.

The next issue under consideration is the shortage of personnel in important health care occupations in the Department of Medicine and Surgery. These positions include, but are not limited to, nurses, pharmacists, physical therapists, and occupational therapists.

The problems that now exist in the recruitment and retention of personnel in these occupations are certainly no great surprise to The American Legion. They have culminated for a number of reasons, some of which were avoidable and others that were not.

There are problems in recruiting and retaining nurses on a widespread basis across the nation in both the public and private sectors. The problems, of course, are more complex in VA than in say community hospitals, because even when special pay rates are implemented at a VA medical center, they are usually inadequate in comparison with what is being offered in the private sector.

This is all very reminiscent of the situation that developed in 1981 and 1982 with respect to a critical nursing shortage in the VA.

Going back a few years, it was our feeling that the enactment of the provision of PL 96-330 that established a nurse scholarship program would help improve the recruitment and retention of these health professionals. However, funding has been sporadic in that there has not been an appropriation for new scholarships since FY 1985.

It was encouraging to hear that the administration requested $6,000,000 to support almost 300 nursing and physical therapy scholarships in FY 1988, but that will do nothing to help the immediate situation.

Not only are fewer nurses being trained in the United States, but increasing numbers of nurses are also being diverted from the traditional hospital environment to new positions in areas such as outpatient medical clinics and home health care settings.

The shortages in pharmacists and physical and occupational therapists can be at least partly attributed to the administration's zealous attempts to save money by reducing the number of GS 11-15 positions in the Veterans Administration. The American Legion has expressed its concerns and objections to this grade adjustment initiative numerous times, beginning in early 1984, because of its anticipated impact on the VA medical care system.

We have reviewed the draft report of the 1986 Survey of Health Occupational Staff, prepared by the offices of Personnel and Labor Relations, and Information Management and Statistics of the VA's Department of Medicine and Surgery. The report contains a substantial amount of statistical data relating to shortages in the fields of registered nurses, licensed vocational nurses, nursing assistants, pharmacists, physical therapists, and occupational therapists.

However, statistics do not reveal the entire story. The VA survey was completed in a 14 day period in December 1986, and covers the period of October 1, 1985 to September 30, 1986. We have reviewed a number of our reports on site visits to VA medical centers prepared by the Legion's National Field Representatives between February 1985 and March 1987, and we would now like to provide the Subcommittee with information lifted from these reports which reflect both the extent and the urgency of the existing situation.

Boston, Massachussetts VAMC, February 1985 - "There are 27.4 registered nurse (RN) and 12.0 licensed practical nurse (LPN)/nursing assistant (NA) vacancies. On March 1, 1985 it is expected these figures will rise to 34 RN and 13 LPN/NA vacancies. The reason for the turnover is that salaries, plus other benefits offered in the private sector make it impossible for the medical center to compete to effectively retain or recruit qualified personnel.

"There are vacancies for three pharmacists, however, it was reported that recruitment is no problem. The problem is the GS 11-15 grade reduction froze the positions so they cannot be filled. Overall staffing was deemed as being manageable but if the vacancies previously mentioned could be filled, the service could operate better. It was noted that there is a high turnover of pharmacy technicians and recruitment is difficult in this area because of salaries offered in the private sector."

Fort Lyon, Colorado VAMC, March 1985 - "The Chief reported that recruitment of qualified pharmacists is a problem. There has been a vacancy for a pharmacist since November 1984. There were 24 applicants on the register, however, only two individuals replied. The salaries that are offered are not competitive and the problems of recruitment will remain the same until the VA begins to pay more."

Portland, Oregon VAMC, March 1985 - "Pharmacy Service has a vacancy for one pharmacist and two technicians. The difficulty in recruiting pharmacists has become steadily worse. Personnel come to the VA to gain experience, then they leave. Often, the best leave. The VA salaries, according to the Chief are $10-$15,000 less than other sister hospitals. The situation is such that recruitment and retention of pharmacists has become a District issue. Quality care is predicated on a quality staff."

Sheridan, Wyoming VAMC, June 1985 - "There has been an occupational therapy vacancy for nearly a year. There has been only one response to the recruitment efforts because of the paltry salary the VA offers. A physical therapy vacancy was filled by chance after being vacant a year when a therapist passing through the area decided to stay."

Martinez, California VAMC, June 1985 - "The main issue affecting the delivery of quality services is the recruitment and retention of pharmacists. The salary, even with a special rate, is simply not competitive. A pharmacist leaves almost every other month. Consequently, someone is always in orientation and personnel are always being trained. The VA salary is roughly $10,000 behind the salaries of other local hospitals. Additionally, transferring pharmacists from other states come to the VA long enough to get a California license, then they leave. At present, recruitment is ongoing for a full-time and a part-time pharmacist. An ad in the paper generated only three inquiries. Obviously, this is a serious problem which must be addressed. Special salary rates do not seem to be a viable solution because they are not large enough and the process is so time consuming the VA is quickly out of competition again.

"Another facet of this problem is the OPM classification standards. According to reports, the affiliated schools of pharmacy have a six year program. Offering a graduate a salary at the starting level is ridiculous. The current classification standards were written in 1968. About a year and a half ago the standards were rewritten but OPM closed out classification changes. Consequently, there has been no action on this although it was assessed to be a step in the right direction.

"The recruitment and retention problem is compounded by the GS 11-15 reduction. The salaries are already non-competitive then the facilities face the prospect of placing a cap on the number of pharmacists because they represent a high percentage of the GS 11-15 employees."

San Francisco, California VAMC, June 1985 - "Pharmacy Service: The main problem affecting the service is the recruitment and retention of personnel. According to the Chief, there are 250 vacant pharmacist positions in the system. There are four pending vacancies at this center and 2.5 technician vacancies; 50 personnel were reported to have left during the past two years. Last year, 7 pharmacists resigned in a couple of months. The VA salary is simply not competitive both for pharmacists and technicians. Janitors make more than trained techs.

"Special salary rates have been received but they are trifling. By the time the process is completed, the salaries are behind again. Conversion to title 38 was assessed as at least helpful in some respects. It would facilitate hiring and help to some degree with salaries.

"Nursing Service: The Chief expressed her concern about the erosion of the salary gains which have made the VA competitive in hiring nurses. With more jobs being available in the private sector and the VA not keeping pace with pay increases, a collision course throwing the VA back into a nursing coverage crisis is envisioned. For FY 1984, the turnover rate was 18.6%. However, since personnel have been on special salary rates, they have not received cost-of-living-increases. Thus, the gains of the special pay have been eroding. The station requested a 3.5% increase, which it would pay, but this was denied through OPM. The net result is an increased turnover rate to 26.8% this year, and declining morale. The cost-of-living is very expensive in this area, and this must be recognized. Moreover, there is no pay differentiation for the quality and capability of nurses. As reported, nurses can earn $5,000 more in the private sector by improving their skills. In general, the VA in this area is beginning to steadily fall behind in their compensation of nurses, and this will inevitably impact on recruitment and retention."

Altoona, Pennsylvania VAMC, July-August 1985 - "Rehabilitation Medicine Service (RMS): There will be a vast improvement of space and equipment when the ambulatory care addition is completed. The biggest concern is whether there will be any employees to operate the programs. When a vacancy occurs, the chances of filling it are impossible. Starting salaries in the community or occupational and physical therapists are thousands of dollars higher than experienced therapists are paid in the VA.

"During the survey, there were no occupational therapists and only one physical therapist. The last physical therapist is expected to leave in September when a new Rehabilitation Hospital opens about two miles from the VA. Needless to say, treatment programs have had to be reduced considerably. Bedside care has been curtailed which impacts significantly on NHCU. Without financial assistance, veterans services will suffer immeasurably."

Allen Park, Michigan VAMC, September 1985 - "Due to the inability to compete with the over 50 community hospitals in the Detroit area for salaries and benefits, PT is done on a strictly contractual basis. The authorized ceiling for PT is 12.0 FTEE, yet, there are only 3.8 physical therapists. Two are contracted out at $24 an hour and the

remaining 1.8 receive $18.50 an hour. During the month of July 1985, the total cost for contracted services was $12,296. Vacant positions exist for 6.0 physical therapists, GS 9 and 1.0 Supervisor, physical therapist, GS 11. The last physical therapist left in the Fall of 1984 and none of the positions are expected to be filled.

"The authorized ceiling for OT is 9.5. Vacancies for 2.0 FTEE have existed in this area since November 1984."

"Pharmacy Service: The problem of salaries not being competitive with that of the private sector was discussed. Even at the GS 11 level, salaries are $5,000 less than what is offered, not including very attractive benefits. Due to the GS 11-15 grade reduction, pharmacists are attempted to be hired at a GS 9 level. There are currently vacancies for a GS 11 pharmacist and a GS 4 pharmacy technician."

"Nursing Service: Vacancies existed for 8.4 FTEE registered nurses (RNs) and 3.6 FTEE licensed practical nurses/nursing assistants (LPNs/NAs). Areas cited to be in need of the most support were critical care and the medical wards, including intermediate medicine. Special Pay Rates are established for associate and junior grade nurses, yet, not for RNs. A difference of about $2,500 in salaries is experienced for RNs. This does not include other benefits, such as tuition reimbursements and free health care plans."

Montrose, New York VAMC, September 1985 - "The ability to hire occupational and physical therapists is greatly hindered by the lack of competitive wages. It was stated that a new PT graduate can make $9,000 more per year in the community. One PT vacancy was filled after three years by a corrective therapist. Temporaries and therapist assistants are also used to fill PT and OT vacancies. This places a burden on an assistant who may have to work alone while treating veterans.

"When a SERP Team surveyed this facility in July 1985, there was a backlog in physical therapy because of the shortage of therapists. This backlog was eliminated by placing veterans on ward programs where nursing personnel were to provide limited treatment. Also, the number of treatments per patient was reduced, along with the amount of time per treatment. This is not ideal treatment."

"Nursing Service: Although this service has the highest complement of nurses it has ever had, they continue to have recruitment problems. Vacancies existed for 6 registered nurses (RNs), 11 licensed practical nurses (LPNs), and 34 nursing assistants (NAs). The recruitment of nurses has improved, but LPNs and NAs remains a problem. LPN positions will always remain vacant until the VA pays equitable wages. They are nowhere near the community salaries and starting salaries are only slightly higher than NAs. Quality NAs cannot be hired because their wages are the lowest in the VA system. Once hired, they will move on after gaining experience or transfer to better paying positions, such as in building management, the laundry, or in dietetics."

Castle Point, New York VAMC, September 1985 - "Rehabilitation Medicine Service: Vacancies for a physical therapist and occupational therapist have existed for about a year. Both positions are difficult to recruit and retain because of the low wages and large demand for their services. Community salaries are very lucrative, ranging from $5,000 to $9,000 more than the VA. Temporary OT and PT assistants are currently being used."

"Nursing Service: Recruitment and retention are the biggest problems facing this service. Vacancies existed for 13 registered nurses, 6 licensed practical nurses, and 2 nursing assistants. Nurse applications are drying up. Ten years ago, the VA was very competitive, but this has changed. Not only have wages and benefits improved in the private sector, but so have career ladders. Some career nurses have also been leaving.

"The acting Chief said that recent candidates have been very aware of impending changes being implemented due to the Grace Commission recommendations. Many applicants are turning down positions with the VA because of the unstability of the retirement program, pay freezes, and uncertainty of career advancement. Many of those accepting positions are just passing through until something better comes along. This has increased the turnover rate for RNs from 22% in FY 1984 to 26% in FY 1985."

Richmond, Virginia VAMC, December 1985 - "Rehabilitation Medicine Service: Employee vacancies included two physical therapists, an occupational therapist, and a case manager. The physical therapist vacancies have existed for about a year. The VA cannot compete with anyone for these therapists.

"To eliminate physical therapy backlogs, treatments for NSC-OPT veterans were

curtailed for a short period. There was also a shift of certain treatments to corrective therapy and a reduction in frequency of others. This is not an ideal arrangement but it was the only way to treat the most veterans possible."

"Pharmacy Service has been severely hindered by the GS 11-15 reduction. Even without this inane mandate, the VA cannot compete with the community. The VA can offer a new applicant $21,800. One new graduate went to a chain store and received $40,000. Every student at the university has 2 to 3 job offers that will start them at $10,000-$15,000 a year more than the VA will pay.

"The Chief said he has lost nine pharmacists since July. They usually only stay long enough to get trained or until better offers materialize. Two pharmacists were lost shortly after they started for the latter reason. Four pharmacist positions were recently converted to technicians just to get some bodies in place. If some relief is not forthcoming soon, the pharmacy may have to begin converting back to ward stock."

Birmingham, Alabama VAMC, February 1986 - "Pharmacy Service: Staffing shortages present a problem for this service. Currently there are 4 vacancies for pharmacists and the situation is not improving. Because of low salaries, non-ability to gain term appointments, and the GS 11-15 grade reduction, veterans who need medication are the ones who must suffer. This medical center has 414 operating beds. The total staff consists of 37.0 FTEE. With 853 operating beds, the University hospital has 80 pharmacists and 70 pharmacy technicians."

Atlanta, Georgia VAMC, February 1986 - "Pharmacy Service: Recruitment is ongoing for 3.5 pharmacists and one technician. There are difficulties and challenges in recruiting personnel, but even more so in retaining personnel. The local drug store chains pay pharmacists around $32,000. The VA salary is not competitive. This is further complicated by the GS 11-15 grade reduction. Alternatives, like part-time employment are not feasible. Many people use the VA to gain experience then move to higher paying positions."

Milwaukee, Wisconsin VAMC, April 1986 - "Pharmacy Service: The main issue affecting this service is the recruitment and retention of pharmacists. The VA salary simply is not competitive. Graduates coming out of school are offered $30-$35,000 by private chains, while the VA salary is about $25,000. This center has sought special rates, but they have been turned down once. As many as 7 vacancies have been encountered. Some pharmacists use the VA for training then leave. However, the greatest concern is that career people are beginning to leave. At present, the Service has been managing due to the efforts of the staff and the use of overtime."

Temple, Texas VAMC, April 1986 - "As previously mentioned, the biggest concern facing this service is the lack of pharmacists. There are 3 reasons for this dilemma. One is an overall shortage of pharmacists in the Central Texas area. Second is even though special salary rates are offered for GS grades 9-11, salaries are still not competitive with what is offered in the private sector. And thirdly, the GS 11-15 grade reduction hinders recruitment, even if there was an abundance of pharmacists available and salaries were competitive. These three factors together create an almost impossible situation for hiring necessary personnel. The only solutions are for higher salaries and total exemption from the GS 11-15 grade reduction."

Waco, Texas VAMC, April 1986 - "Pharmacy Service: The biggest problem facing this service is the 6 pharmacist vacancies. Actually, 8 pharmacists are needed yet only 6 have been approved. Even at special salary rates, salaries are not competitive with the retail chain stores. Other factors are the GS 11-15 grade reduction and general shortage of pharmacists in Central Texas."

Saginaw, Michigan VAMC, April 1986 - "Rehabilitation Medicine Service (RMS): The staff of RMS consists of a physiatrist, a physical therapist assistant, and an occupational therapist. There is a need for a physical therapist (PT), but there are only funds available for another PT assistant. If funds were available, it is unlikely the VA could recruit one because they cannot compete with the community.

"Under current conditions, bedside care and outpatient treatments have been eliminated. The staff cannot maintain the inpatient workload. Besides affecting veteran care, the hospital is losing about $8,000 a month in outpatient reimbursements. The Chief operates a clinic once a week. A two month backlog exists to get into the clinic. The maintaining of records and reports is also behind because secretarial support was reduced significantly due to budget cuts.

"There is much concern by the PT assistant. She is seeing 25 patients a day, nearly double that being seen in the community. She cannot be as thorough as she would like. There is also the fear that she may loose her license because she is not working under the supervision of a registered physical therapist.

"The occupational therapist said they are short of funds to purchase supplies. Cheaper supplies are procured when possible, but they are not always the best functioning products for patient needs. Some patients have been denied certain activities because the items were not available."

"Recruitment and retention of nursing personnel fluctuates regularly. Last year 15 registered nurses turned over. The turnover rate has been increasing over the past few months. The VA is competitive for recent graduates, but cannot compete for experienced nurses due to salaries, benefits and continuing educational packages. The most difficult positions are experienced critical care nurses. The VA places a lot of effort and time into training these nurses, then loses them to the community.

"There is much concern among nursing personnel regarding government employment. The rumors surrounding possible changes in retirement, wage grades, reductions in force, etc., are making everyone uneasy and questioning internally whether they want to make the VA a career."

Poplar Bluff, Missouri VAMC, June 1986 - "The one physical therapy position has been vacant for three years. One therapist filled the slot for about 4 months, but left when a better paying community position became available. A physical therapist from another VAMC is expected on station before the end of July. During this 3 year period, the one corrective therapist has had to split his time between CT and PT. Bedside treatments and outpatient care have had to be sharply curtailed to maintain the quality of care. Only about eight veterans can be maintained on an outpatient basis at any one time."

Miami, Florida VAMC, June 1986 - "The concerns about the impact of the DRGs and staffing resources are the two main issues confronting this Service. From the Chief's perspective, the Service is understaffed and consequently the treatment level is less intense than desired. The 3.6 FTEE of physiatrists is not enough for physician rounds and consultation. There are three occupational therapist (OT) position vacancies and two more pending vacancies. The VA is not competitive because salary is not commensurate with the private sector. With the current and projected vacancies patients are treated on a priority basis and it may be necessary to close clinics."

"Pharmacy Service: There are 3.5 pharmacist and 2 technician vacancies. Special pay has been provided to assist recruitment, but the VA still is not competitive with the private chains. As reported, local chain stores are paying in the area of $34,000 to $37,000 while the VA is anywhere from $7,000-$10,000 behind them. Putting pharmacists under title 38 was viewed as beneficial. The service is maintaining services by using overtime. However, it was noted, pushing people to do more usually increases the error rate."

Kansas City, Missouri VAMC, June 1986 - "Employee turnover during the previous year was described as high. The VA cannot compete well with the community. The GS 11-15 reduction has had a negative impact also. Once a pharmacist completes the first year of employment, it is unlikely he will be promoted from GS 9 to GS 11. One pharmacy technician and 1.5 pharmacist vacancies were on 90 day lag hiring at the time of the visit. A memo to have this waived was submitted to the Position Management Committee because the vacancies are expected to hinder outpatient operations."

"Nursing service had vacancies for 6 registered nurses. They are on a 90 day hiring lag, except for critical care areas. There are also 10 licensed practical nurse positions vacant, but there is no authorization to fill them. Hospital management said they are being used to hire over ceiling graduate nurses.

"The Chief said ten additional registered nurses are needed to provide better evening coverage on the medical and surgical units. They are attempting to maintain a lower level of overtime through the use of compensatory time. One month of overtime prior to this was about $27,000. It has also been difficult to provide everyone with the vacation time scheduled.

"The employee turnover rate is about 22%. The two biggest complaints received by employees leaving is because of the workload and the scheduling. Nurses from the community were said to be astonished at the amount of workload assigned each staff

member. Up until a year ago, nursing personnel had to do bed washing. The staff cannot continue at the high pace at all times before burnout sets in. This was very obvious on one high intensity unit during a tour with the Chief of Nursing Service."

Oakland Park, Florida OPC, June 1986 - "There are also three pharmacist vacancies and a pending technician vacancy. This has obviously impacted on the pharmacy's efforts to maintain timely services, and it has resulted in the use of a large amount of overtime. A pharmacist is to be received on loan from VAMC Miami for a 90 day assignment. The problem is the desparity in pay between the VA salary and the local community. As reported, the VA can pay about $28-$29,000 while outside a pharmacist can make $38,000."

Riviera Beach, Florida OPC, June 1986 - "Similar to facilities around the country, there have been challenges recruiting pharmacists. The VA is offering approximately $26,000 while outside sources are offering $36,000. Obviously, the VA is not going to be competitive. The most recent vacancy remained opened for three months. This is a problem which needs to be addressed on a national basis."

Louisville, Kentucky VAMC, August 1986 - "Since new programs have been added, all the therapists are overworked. The Service was originally short-staffed due to an ongoing physical therapist (PT) vacancy, and now at least another part-time PT is needed. Additionally, recognition of the need and approval to establish another occupational therapist (OT) position will be sought. Recruitment of these therapists is a challenge because government salaries have not been competitive despite the help of recent legislation to place these positions under title 38 salary authority."

"Challenges have been incurred in recruiting full-time pharmacists. Currently, 3.4 vacancies exist. Salary adjustments were received in March/April 1985 and another request has been submitted. Starting salaries are improved by the rate increase, but the VA remains non-competitive in competing with the chain stores for full-time experienced pharmacists."

"Nursing Service: Using various models of study, a conservative estimate is that the service is 20-30 positions below what should be authorized for the current workload. Studies have been continued to identify staffing needs. Given the realities of the current budget, these positions will be difficult to realize. Within the current ceiling, there are approximately nine registered nurse (RN) vacancies. Recruiting for RNs in the Louisville area has fluctuated. Nurse technicians/graduate nurses have been used to fill vacancies. Recruiting for licensed practical nurses (LPNs) and nursing assistants (NAs) has been comparably easier."

Columbia, Missouri VAMC, September 1986 - "Pharmacy Service: The lack of sufficient personnel is a major concern. Currently, vacancies exist for 3.2 pharmacists and 4.0 pharmacy technicians. Even though pharmacists can be hired at a GS 11 level, the salaries offered are non-competitive and vacancies have existed for over a year. The vacancies for pharmacy technicians are very recent and four, who were hired as GS 5s, just left in August to go back to school."

Tacoma, Washington VAMC, September 1986 - "Nursing Service: Although the emergent need to augment the nursing staff at this facility has continuously been acknowledged by VACO for years, very few resources have been provided to alleviate this need. When inpatient wards containing a total of 73 beds were closed in building 85, some 45 nursing positions were redistributed throughout the medical center. Despite 35 existent vacancies in the Nursing Service, the Chief indicated that the present level of nursing staff was adequate to handle the current workload. The threat of further nursing reductions in FY 87, however, is looming and further reductions in the nursing staff will negatively impact on patient care.

"The Chief complaint raised by nurses in the wards involved Building Management. Buildings 81 and 61, in particular, reflect a lack of good housekeeping. Nurses are required to perform all terminal cleaning in addition to their other duties.

"As a rule, the Chief has not hired part-time nurses. Although recruiting for RNs has not been problematic, recruiting for LPNs and intensive care nurses has been difficult. A number of nurses annually transfer to the State medical system."

Cincinnati, Ohio VAMC, October 1986 - "A major concern, however, is the professional nurse salary structure at the intermediate and senior grade levels. This facility has great difficulty recruiting specialty registered nurses (RNs) for intensive care, operating room or psychiatric care. This fact is attested to by having a constant

10 percent professional nurse vacancy rate. Currently, there are 40 nurse vacancies.

"The service's FTEE ceiling and budget is sufficient to recruit the 40 vacancies. The major category of nursing where no recruitment problems were reported was at the entry level. Beyond that level, for RNs, the VA has no comparable incentives to offer, vis-a-vis the private sector.

"The VA has phased out the scholarship reimbursement program and has no provision to provide tuition reimbursement. Individuals with career tracks in nursing have no inducement to advance their careers within VA. It was remarked that this issue has to be seriously reviewed at the VA Central Office level and brought to the attention of Congress."

Nashville, Tennessee VAMC, October 1986 - "Nursing Service: The major concern facing the Service is retention due to non-competitive salaries for registered nurses (RNs). There is an abundance of health care organizations within the Nashville area and all of them are competing against each other offering salaries, preferred work schedules and numerous benefit packages to attract RNs. Presently, special salary rates are offered to RNs at the junior level. These rates were approved on April 2, 1985 and are no longer competitive based upon merit and cost of living increases other facilities have implemented since that time. A request has been forwarded to VACO and OPM for increased rates and to also offer special salary rates at the associate nurse level. No response has yet been received.

"Because of the retention problem, not all of the critical care units are staffed solely with RNs. This problem will continue until recruitment and retention improves. Direct patient care on other wards would be affected if RNs are taken from these areas to staff the ICUs.

"More work is being required from nurses, especially when certain areas are at maximum census. It was reported that the general medical and surgical wards are now being strained. Also, there is a high number of evening admissions which requires more work with less staff. Overtime usage is also up and in the first quarter of FY 1986, over 1,000 hours were used."

Martinsburg, West Virginia VAMC, November 1986 - "Pharmacy Service: Since its inception the program has been understaffed. There are two issues tied together here. One is the receipt of VACO funding for the program. The other is the problem recruiting and retaining pharmacists due to the salary structure. In August, four pharmacists resigned within a month. Coincidental, the Chief had 1.6 FTEE which never could be filled. At present, there are two pharmacist vacancies. A salary survey was conducted. As reported, the VA is $2,000-$5,000 behind the average pay in the community hospitals, and about $9,000 below the salary offered by chain drug stores. While authority is received to bring new people in at higher grades, this presents morale problems because new employees then make higher salaries than established employees. A pay adjustment is needed to address recruitment and retention issues. VACO funding has been needed to properly support the program."

Brockton/West Roxbury, Massachusetts VAMC, November 1986 - "Pharmacy Service: This service is providing the best possible service under extremely difficult circumstances. While the timeliness of service, especially at the Brockton Division is below expected criteria, this situation is not reflective in any way on Pharmacy Service management. Rather, the average 3.5 hour outpatient prescription waiting time and extremely low pharmacy employee morale is reflective of the overall medical center fiscal situation. In conversations with the Chief and Assistant Chief, it was learned that available manpower is critically short. There was a ceiling of 33 FTEE to handle all facility pharmacy operations at the time of this survey. VA Central Office FTEE criteria for an operation of this size is 44."

"Nursing Service: The recent consolidation of ward 3-5-B has helped to alleviate some staffing pressures on this service. However, in the Chief's own words, the immediate issue facing the medical center is survival. It is very difficult to absorb as much of a one-year budgetary reduction as this facility did beginning in FY 86, continuing into FY 87, and still maintain the same level of services. Between the two Divisions, it appeared that the Brockton Division was experiencing the greatest nurse staffing pressures.

"A shortage of phsychiatric nurse staffing, as cited in the most recent JCAH survey, has been improved. However, in order to improve one staff area, resources have to be diverted from other areas. The recent large increase in medical capabilities at the

Brockton Division have to have accompanying nurse staffing. Although many hospital personnel alluded to a severe nursing shortage, this issue was not detailed in depth by the Chief Nurse. This is understandable as sometimes there is a certain reluctance to share bad news with an outsider."

Livermore, California VAMC, - November 1986 - "RMS is badly understaffed to perform its mission. The hospital's increase in extended care services has created additional demands for rehabilitative therapy. According to VA Central Office (VACO) staffing guidelines, physical therapists (PTs) and occupational therapists (OTs) should accommodate no more than 10-12 hospital or nursing home care unit (NHCU) patients per day. According to the Chief, PTs and OTs are providing therapy to 25-30 inpatients a day, on the average. RMS provides 1.5 PTs and 2 OTs daily to the NHCU and the same number of PTs and OTs to hospital inpatients and outpatients. At this rate, RMS should be authorized an additional 7-8 physical therapists and 6 occupational therapists. Due to the staffing shortage of therapists, the outpatient waiting list for service-connected veterans is two months and about 10-12 months for nonservice-connected veterans.

"The Chief stated that her immediate objectives and needs were to obtain special salary rates for physical therapists, secure additional space, develop and document workloads, and obtain incremental staffing. Although physical therapists are under title 38, they are nearly impossible to recruit or retain unless special salary rates are approved.

"Nursing Service: According to the Chief of Nursing Service, who has been here 10 years, the nursing staff has 8 RN and 18 licensed vocational nurse (LVN) vacancies.

"The Chief's major concern has been high turnover rates in the nursing ranks particularly with regard to LVNs. VA nursing salaries and benefits cannot compete with community nursing salaries throughout the State of California. Special salary rates and cost of living allowances (COLAS) are urgently needed particularly to recruit and retain LVNs.

"Retention and recruiting of nurses and other technical specialties at VAMC Livermore is a serious problem which requires VA Central Office (VACO) assistance. The hospital is experiencing high employee turnover rates as VA salaries in certain specialties are no longer competitive with those offered by community health care facilities in VA Western Region. VACO assistance is required to fund special salary rates for RNs and licensed vocational nurses (LVNs), pharmacists and pharmacy technicians, physical therapists, police officers, medical technologists, and clerical personnel at Livermore VAMC.

"Due to the heigthened role of Rehabilitation Medicine in extended and long term care centers, VACO needs to reassess the current rehabilitation staffing criteria for medical centers, like VAMC Livermore, with an eye toward upwardly revising rehabilitation staffing capabilities. Rehabilitation for outpatients, extended care and NHCU patients requires intensified rehabilitative efforts which are not being met with current staffing criteria. The ratio of patients to therapists at VAMC Livermore vastly exceeds VACO established standards."

Togus, Maine VAMC, November 1986 - "A PT position has been vacant since August 1986. No candidates have been found. OT has had two vacancies: One since October 1983 and one since October 1986. Clinics are occasionally closed due to the current staffing pattern especially when someone is on leave. Recruitment may be affected by geographical location, but consistent with comments received from VAMCs across the country, VA therapist salaries are not competitive with the private sector.

"Nursing Service: There have been problems recruiting licensed practical nurses (LPNs) and some challenges obtaining qualified registered nurses (RNs) for the intensive care unit. At the time of the visit, nurses were committed to duty for the RN vacancies, but there were five (5) LPN vacancies and one nursing assistant (NA) vacancy. The station had been advertising 2-3 months for LPNs. Two factors affect LPN recruitment: The low salary and the functioning level allowed by the VA. In the private sector LPNs can often be in charge of units. This is not permitted in the VA. Personnel service has been requested to do a salary survey to assess the adequacy of the current salary structure."

Reno, Nevada VAMC, November 1986 - "The Director indicated that her major concern was obtaining special salary rates for such specialties as pharmacists, respiratory therapists, nuclear medicine technicians, radiology technicians, ultrasound technicians and physical therapists. It was reported that the State of Nevada,

particularly in the metropolitan Reno area, had one of the highest cost of living rates in the country. Hospital costs in Nevada were also becoming prohibitive. It was mentioned that licensed practical nurses (LPNs) at the VAMC were only at 25 percent of authorized ceiling as VA salaries were simply not attracting or retaining nurses. It was particularly demoralizing that certain specialties such as registered nurses (RNs) and engineers who were receiving special salary rates were ineligible to receive raises in cost of living allowances (COLAS).

"At the time of the survey the pharmacy service had two pharmacist vacancies and was expecting a third vacancy.

"Pharmacists are not under title 38 and they should be. According to the Chief, the pharmacy is experiencing a 50 percent turnover in pharmacists. Most pharmacists are leaving for better paying salaries in the community shortly after they have gained the requisit experience in the VA system. The Chief has been totally disillusioned with the quality of newly hired pharmacists. Additionally, the recently installed civil service retirement plan has not been competitive with similar plans and benefits offered by medical care providers in the private sector. The pharmacists being retained at the VAMC are under the former retirement system. Pharmacist vacancies impacted on employee morale, vacation scheduling and prescription filling times and prescription instructions to patients. Although relief from the GS 11-15 restrictions is required , it was noted that these reductions have had little impact because the pharmacy was already experiencing 50 percent turnover in personnel. Bringing pharmacists under title 38 authority was imperative, but the Chief strongly advocated that VA Central Office needed to approve and fund special salary rates immediately. This was essential for pharmacists particularly in the Western Region in order to recruit and retain quality people in the VA system.

"Due to the shortage of pharmacists, nurses operate the satellite pharmacy after duty hours.

"In closing, the Chief emphasized that the Classification 660 Pharmacy Series publication needed revision. The current classification was issued in February 1968 and is no longer an accurate classification for current pharmacists. For example, the journeyman pharmacists need to enter at the GS 12 grade level and stiffer qualifications were required to support higher GS grades.

"Nursing Service: The Chief of the Nursing Service indicated that there were 11.8 licensed practical nurse (LPN) vacancies and 4.6 nursing assistant (NA) vacancies. According to the Chief, the VA medical center was unable to compete with salaries offered to nurses in the private sector. Improved salary scales for both RNs and LPNs needed to be implemented. Based on a survey conducted last Spring, the hospital was requesting that VA approve and fund over $219,000 per year in special salary rates for RNs and $192,000 to recruit and retain LPNs.

"As previously noted, two ICU beds were closed due to the shortage of this specialized nursing staff. The nursing staff experienced a 39% turnover rate in FY 86."

Bay Pines, Florida VAMC, February 1987 - "The biggest problem facing the Service is the need for a competitive salary. At the time of the visit there were 17 pharmacist vacancies. These positions were once filled but vacated, primarily, because higher salaries can be earned elsewhere. A local chain is offering $42,000 per year, while the VA salary for a comparable starting position is $31,702 per year with a $1,500 differential. The VA is behind by $7000-$8000 per year for anyone with a license. Consequently, there has been a mass exodus. Moreover, applications are not being received, and those that are received, frequently, involve individuals with questionable backgrounds.

"The workload has been managed by instituting mandatory overtime, reducing the hours of the inpatient pharmacy, requiring supervisors to do routine work and hiring more technicians although there is now a lack of supervisors. Specialist activity has been eliminated and all efforts are concentrated on delivering drugs.

"A salary survey was taken and application for special salary rates was made. It took seven months for processing, and then, the clinic pharmacists at the Fort Myer OPC were excluded. The rates became effective at the beginnning of February so effectiveness could not be determined yet. Nevertheless, the frustration about the bureaucratic entanglements of getting an increase were apparent.

"This situation exemplifies a critical situation experienced by the VA in various parts of the country. Salary rates are not determined nationally, so, potentially, individual stations are competing against one another as they are able to provide better salaries via special salary rates."

West Los Angeles, California VAMC (two divisions), February-March 1987 - "At the time of this survey, there were 75 registered nurse (RN) vacancies, with 9 pending and 27 licensed vocational nurse (LVN) vacancies. All of these vacancies were within the Wadsworth Division. Primarily, low salaries, vis-a-vis the private sector and a woefully inadequate non-salary benefits package was the thrust behind the RN and LVN vacancies. Nursing personnel are very frustrated with this situation, overworked and many are still likely to resign if conditions do not rapidly improve. Several acute care wards have been consolidated due to the nurse shortages and only 50 percent of the Surgical Intensive Care Unit (SICU) beds are operational (8 of 15 SICU beds).

"During the period of this visit the already inplace nurse special salary rates were increased approximately $3,000 to $5,000 for RNs. Still, the Chief Nurse commented that comparable salary is only part of what is necessary to recruit and retain RNs. The private sector is providing substantial non-salary benefits to professional nurses. In this regard the VA has alot of catching up to do.

"For pharmacists, physical therapists and occupational therapists the GS 11-15 grade restrictions have had a devastating affect on recruitment and retention. At the Wadsworth Division, of 15 physical therapist positions, only 1 (the supervisor) was above a GS 9 grade (GS 12). Los Angeles has a very high cost of living and the VA cannot compete with the private sector in recruiting and retaining the better qualified people. This situation was found to permeate all the way down to the lower GS salary grades.

"At the Brentwood Division (long-term care) privately contracted physical therapists are on duty at $36 per hour for six hour days just so the Division can have basic physical therapy staffing. Both Divisions have numerous vacancies in pharmacy, occupational and physical therapy. However, these staff positions are not the only shortages currently being experienced. This facility is not only in bad shape financially, but, it cannot compete with the private community in most professional and non-professional occupations." (This information was taken from a memorandum on West Los Angeles. The full visitation report of this survey will provide further information on these issues).

Tampa, Florida VAMC, March 1987 - "The most significant issue affecting the delivery of services is the retention of pharmacists. At the time of the visit, there were 5 pharmacist vacancies. These were in the process of being committed. Pharmacists can be recruited, but their average length of stay is only eight months. People are here to get their board certification, then they leave. This VAMC has received three salary differentials in the past fourteen months. Nevertheless, the medical center has lost all but two of its inpatient pharmacists, and pharmacist slots have been converted to technician slots so coverage can be provided. For a while pharmacists were working mandatory overtime. At present, pharmacists are getting placed back on the floors but the situation will not be resolved until a competitive salary structure is established."

It is obvious that some changes are going to have to be made, including improved benefits for these employees, or the problems will only continue to worsen.

We commend this Subcommittee for its vigilance in placing this important problem on the agenda for today's hearing, thus making it an issue of badly needed discussion.

Mr. Chairman, the third issue that we have been asked to address this morning is H.R. 1659, a bill containing two sections, both of which relate to State Veterans Homes.

Section 1 of this measure would amend section 641 (a) of title 38 by increasing the per diem rates for payments by the Veterans Administration to State Homes for care provided to veterans.

The per diem rate for domiciliary care would be increased from $7.30 to $9; the rate for nursing home care would increase from $17.05 to $20.35 and the rate payable for hospital care would be increased from $15.25 to $20.35.

The American Legion strongly supports this proposed increase in per diem rates.

We are mandated through Resolution No. 195, adopted by the Delegates to our 1986 National Convention, to support an annual review and revision of the rates of reimbursement by the Veterans Administration for the care provided veterans in State Homes.

The last increases in per diem rates were set forth in PL 98-160, effective April 1, 1984. We are very much aware that 38 U.S.C 641(c) currently requires the Administrator to submit a report every three years to the Committees on Veterans Affairs on the adequacy of the per diem rates payable to each State for domiciliary, nursing home and hospital care for each veteran receiving such care in a State Home. The first report was to have been submitted not later than June 30, 1986. The American Legion believes that the fair sharing of the cost of providing extended care for elderly and disabled veterans will encourage States to meet the needs of the aging veteran population, and we urge that the per diem rates be increased as set forth in this measure, keeping in mind that they have not been increased for three years.

Section 2 of this measure would amend title 38, chapter 81 by providing that the Administrator may award transition-year grants at any time after July 1, 1987. The grants for State Home construction would be awarded in the order of their priority on the transition-year list as established under PL 99-576.

The American Legion has no objection to this proposal.

Mr. Chairman, that concludes our statement.

STATEMENT OF CONGRESSMAN JIM KOLBE, ARIZONA
BEFORE THE HOUSE COMMITTEE ON VETERANS AFFAIRS
APRIL 22, 1987

I wish to thank the Honorable Sonny Montgomery, Chairman of the House Committee on Veterans Affairs, for the privilege of contributing to this most important hearing on recruitment and retention of Veterans Administration officials. I wish to address Veterans Administration pharmacists in my district, Southeastern Arizona, specifically.

I am including a survey recently conducted to assess recruitment and retention of health professionals in the VA as it pertains to pharmacists. Of the stations reporting vacancies a total of 290.67 FTEE pharmacists vacancies existed in February 1987. It should be noted that 88 stations reported a turnover rate of 20 to 83% of staff annually. The time necessary to recruit replacements was at least 24 weeks in 43 stations. Of particular note is that 10 stations required more than 50 weeks to fill vacancies.

Recruitment of pharmacists for the Tucson VA Medical Center will potentially become more difficult in the next few years. The University of Arizona College of Pharmacy has completed a manpower survey which has been independently confirmed that 150 pharmacists will be needed in Arizona annually as the population increases. The number of pharmacists that will be graduating from the University of Arizona will decrease to about 45 to 50 annually when the Doctor of Pharmacy program is fully implemented (the class of 1991 will be the first class to receive a Doctor of Pharmacy degree). This also means that in 1990 there will not be a graduating class of pharmacists from the College of Pharmacy. The major demand for pharmacists, the decreased class size, and having one year when no pharmacists will graduate will increase the competition for pharmacists, which will mean further escalation in salaries. I have recently learned that community pharmacists in California are earning approximately $50,000 annually. Supervisory hospital pharmacists are earning between $37,000 and $47,000 annually, and a few chief pharmacists in hospitals are earning over $60,000 annually. Not only will these salaries impact on those VA Medical Centers in California but will cause a spillover effect on salaries in Arizona.

Quality of care is the precise problem that is of concern to me. The veteran population is aging. All projections demonstrate a marked rise in the number of veterans who will be eligible for care in the Veterans Administration. The increased workload will add pressure to increase productivity at a time when recruitment and retention are more difficult. The outcome of shrinking staffs and increased workload will be less time available to perform patient specific drug related consults that will improve the utilization of medication, decrease toxicity, and potentially lower the total cost to the Agency.

Additionally, the potential for errors when prescriptions are filled and checked will be increased. To illustrate this potential, I would note the number of prescriptions being filled in the outpatient pharmacy of the Tucson VA Medical Center has risen from approximately 900 to over 1300 daily in the past two years. There has been no increase in staffing (although it is certainly justified according to staffing guidelines) to

offset the increase in work. The inpatient pharmacy workload increased markedly, but at a slower rate than in the outpatient area. A shorter length of stay and the acuity of illness both seen to have increased and will continue to increase markedly. The increased burden for the Pharmacy Service will result in a system that is not as safe. A less safe system increases the risk to the patient and the liability of the Veterans Administration due to medication related problems.

Are there solutions for the problem of recruitment and retention? The answer is unequivocally yes. To accomplish the mission and goals of the Veterans Administration and the individual medical centers a variety of suggestions can be made. I am including a list of ten possible solutions to some of the problems of recruitment and retention that William Jones and his colleagues in the Pharmacy Service have drafted. Probably the most important short term issues are conversion of pharmacists to Title 38 (from Title 5) along with increased salaries comparable to those in the community.

Once again I wish to thank Chairman Montgomery and the Committee for allowing me to present my remarks on this very important subject. You are to be congratulated for giving this issue the attention that it deserves.

PHARMACIST STAFFING REPORT
CALENDAR YEAR 1986

STATION	# OF STAFF PHARMACIST POSITIONS AUTHORIZED	AVERAGE NUMBER OF VACANCIES	ANNUAL TURNOVER RATE	AVERAGE TIME TO RECRUIT	SPECIAL SALARY RATE	REGION	DISTRICT	STATION
NORTHAMPTON	5	0	0	24 WEEKS	NO	1	1	NORTHAMPTON
BOSTON OFC	11	0.6	2%	8 WEEKS	PENDING	1	1	BOSTON OFC
BROCK/WEST RDX	15	3.2	47%	9 WEEKS	NO	1	1	BROCK/WEST RDX
MANCHESTER	9	0.1	55%	6 WEEKS	NO	1	1	MANCHESTER
BOSTON MC	14.5	2	20%	20 WEEKS	PENDING	1	1	BOSTON MC
TOGUS	10	1.0	20%	10 WEEKS	NO	1	1	TOGUS
PROVIDENCE	12	0.08	0	4 WEEKS	NO	1	1	PROVIDENCE
WH RIVER JUNCT	10	0	10%	12 WEEKS	NO	1	1	WH RIVER JUNCT
BEDFORD	6	1.5	83%	17 WEEKS	PENDING	1	1	BEDFORD
BATAVIA	9	0.4	22%	20+ WEEKS	PENDING	1	2	BATAVIA
SYRACUSE	10	3.2	70%	17 WEEKS	PENDING	1	2	SYRACUSE
CANANDAIGUA	10	1.6	76%	13 WEEKS	NO	1	2	CANANDAIGUA
BATH	6	1.9	17%	24 WEEKS	YES	1	2	BATH
ALBANY	24	4.5	9%	6 WEEKS	NO	1	2	ALBANY
BUFFALO	25.5	7.4	71%	26 WEEKS	YES	1	2	BUFFALO
MONTROSE						1	3	MONTROSE
SAN JUAN						1	3	SAN JUAN
BROOKLYN OFC						1	3	BROOKLYN OFC
WEST HAVEN	8	1.2	37%	22 WEEKS	PENDING	1	3	WEST HAVEN
NEW YORK	28	1.0	20%	10 WEEKS	YES	1	3	NEW YORK
BRONX	24	5	25%	25 WEEKS	PENDING	1	3	BRONX
NORTHPORT						1	3	NORTHPORT
NEWINGTON						1	3	NEWINGTON
CASTLE POINT	7	0.8	41%	15 WEEKS	NO	1	3	CASTLE POINT
BROOKLYN						1	3	BROOKLYN
LEBANON						2	4	LEBANON
WILKES-BARRE	19	1	5%	12 WEEKS	YES	2	4	WILKES-BARRE
PHILADELPHIA						2	4	PHILADELPHIA
LYONS						2	4	LYONS
COATESVILLE	9	0	0	N/A	NO	2	4	COATESVILLE
WILMINGTON	6	0.24	20%	20 WEEKS	NO	2	4	WILMINGTON
EAST ORANGE	46	0.7	2%	26 WEEKS	NO	2	4	EAST ORANGE
PITTSBURGH UD	21	2.9	31%	25 WEEKS	PENDING	2	5	PITTSBURGH UD
ERIE	4	0.3	20%	18 WEEKS	YES	2	5	ERIE
ALTOONA	6	1	16%	9 WEEKS	PENDING	2	5	ALTOONA
PITTSBURGH HD	15.5	0.2	6%	6 WEEKS	NO	2	5	PITTSBURGH HD
BUTLER	6	3.9	50%	52+ WEEKS	PENDING	2	5	BUTLER
CLARKSBURG	6	0.4	20%	14 WEEKS	NO	2	5	CLARKSBURG
FORT HOWARD	5	0	20%	4 WEEKS	YES	2	6	FORT HOWARD
BALTIMORE						2	6	BALTIMORE
WASHINGTON DC	35.4	5.4	16%	26 WEEKS	YES	2	6	WASHINGTON DC
MARTINSBURG	13.6	5.8	37%	26 WEEKS	PENDING	2	6	MARTINSBURG

PERRY POINT						2	6	PERRY POINT
RICHMOND	28	9	29%	25 WEEKS	YES	2	7	RICHMOND
HUNTINGTON	7	1	33%	22.5 WEEKS	YES	2	7	HUNTINGTON
HAMPTON	12.5	4	25%	9 WEEKS	NO	2	7	HAMPTON
BECKLEY						2	7	BECKLEY
SALEM	18	0.03	5.5%	2 WEEKS	NO	2	7	SALEM
ASHEVILLE	16	2.9	31.3%	23 WEEKS	NO	2	8	ASHEVILLE
MOUNTAIN HOME	10	1	2%	27 WEEKS	PENDING	2	8	MOUNTAIN HOME
DURHAM	14	1	14.3	25 WEEKS	REFUSED	2	8	DURHAM
FAYETTEVILLE NC	7	4	49.7%	39 WEEKS	YES	2	8	FAYETTEVILLE NC
SALISBURY	11	0.6	6%	17 WEEKS	NO	2	8	SALISBURY
JACKSON	24	2	33%	16 WEEKS	PENDING	3	10	JACKSON
MONTGOMERY	11	0.2	4.5%	4 WEEKS	NO	3	10	MONTGOMERY
TUSCALOOSA	7	2.5	57%	52+ WEEKS	PENDING	3	10	TUSCALOOSA
BILOXI						3	10	BILOXI
BIRMINGHAM	19	2.4	42%	17 WEEKS	PENDING	3	10	BIRMINGHAM
TUSKEGEE	17	4	20%	106 WEEKS	NO	3	10	TUSKEGEE
MEMPHIS	23	1.8	36%	10.2 WEEKS	PENDING	3	11	MEMPHIS
MURFREESBORO	13	1.3	35%	18 WEEKS	YES	3	11	MURFREESBORO
LEXINGTON	26	1.6	8%	33 WEEKS	PENDING	3	11	LEXINGTON
LOUISVILLE	21	5	22%	28 WEEKS	YES	3	11	LOUISVILLE
NASHVILLE	23	0.2	35%	12 WEEKS	YES	3	11	NASHVILLE
TAMPA	42	4.5	49%	20 WEEKS	YES	3	12	TAMPA
GAINESVILLE	20.5	0.2	48.8%	16 WEEKS	PENDING	3	12	GAINESVILLE
LAKE CITY	17.6	4.2	20%	25 WEEKS	YES	3	12	LAKE CITY
BAY PINES	44	4.5	43%	32 WEEKS	YES	3	12	BAY PINES
MIAMI						3	12	MIAMI
DECATUR/ATLANTA	28	6	46%	29 WEEKS	PENDING	3	9	DECATUR/ATLANTA
COLUMBIA SC	16.5	1.2	40%	12 WEEKS	YES	3	9	COLUMBIA SC
CHARLESTON	11.5	0.8	66%	55 WEEKS	PENDING	3	9	CHARLESTON
DUBLIN	5	1	0	52+ WEEKS	NO	3	9	DUBLIN
AUGUSTA	11	1	3%	52 WEEKS	PENDING	3	9	AUGUSTA
DAYTON	9	0.46	22%	24 WEEKS	PENDING	4	13	DAYTON
COLUMBUS OPC	8	0.5	100%	3 WEEKS	PENDING	4	13	COLUMBUS OPC
CLEVELAND	44.5	5	31%	17 WEEKS	YES	4	13	CLEVELAND
CINCINNATI	26.4	2.5	40%	17 WEEKS	PENDING	4	13	CINCINNATI
CHILLICOTHE	5.6	0.2	35%	6 WEEKS	NO	4	13	CHILLICOTHE
ANN ARBOR	17.1	1.3	23.5%	16 WEEKS	NO	4	14	ANN ARBOR
BATTLE CREEK	14.6	0.8	13.6%	36 WEEKS	NO	4	14	BATTLE CREEK
SAGINAW						4	14	SAGINAW
ALLEN PARK	26.4	0.94	30%	7 WEEKS	PENDING	4	14	ALLEN PARK
MARION IN	5	1.7	40%	25 WEEKS	PENDING	4	15	MARION IN
INDIANAPOLIS	32	5.1	9.4%	30 WEEKS	YES	4	15	INDIANAPOLIS
FORT WAYNE	5	0	0	16 WEEKS	NO	4	15	FORT WAYNE
DANVILLE	14.9	3	20%	32 WEEKS	NO	4	15	DANVILLE
MADISON	12.4	0.7	16%	12 WEEKS	NO	4	16	MADISON
MILWAUKEE						4	16	MILWAUKEE
IRON MOUNTAIN	4.2	0	0	2 WEEKS	NO	4	16	IRON MOUNTAIN
TOMAH	3	0	0	N/A	NO	4	16	TOMAH
HINES	47.5	3.7	23.2%	4 WEEKS	PENDING	4	17	HINES
CHICAGO WS						4	17	CHICAGO WS
CHICAGO LS	28	8	20%	8 WEEKS	NO	4	17	CHICAGO LS
CHICAGO NORTH						4	17	CHICAGO NORTH
SIOUX FALLS	13	0.6	15%	4 WEEKS	NO	5	18	SIOUX FALLS
FARGO	10.5	0.2	9.5%	8 WEEKS	NO	5	18	FARGO
MINNEAPOLIS	36	5.4	22%	13.6 WEEKS	YES	5	18	MINNEAPOLIS

ST. CLOUD	3	0	0	0	NO	5	18	ST. CLOUD
TOPEKA	8	0.3	12.5%	13 WEEKS	NO	5	21	TOPEKA
KANSAS CITY	22	4.5	20%	17 WEEKS	NO	5	21	KANSAS CITY
WICHITA	11	0.2	9%	8 WEEKS	NO	5	21	WICHITA
MARION IL	9	0.2	10%	12 WEEKS	NO	5	21	MARION IL
ST. LOUIS	56	11	20%	56 WEEKS	PENDING	5	21	ST. LOUIS
POPLAR BLUFF	5	0.15	20%	8 WEEKS	NO	5	21	POPLAR BLUFF
COLUMBIA MC	15	1.8	40%	37 WEEKS	PENDING	5	21	COLUMBIA MC
LEAVENWORTH	10	0.5	40%	12 WEEKS	NO	5	21	LEAVENWORTH
FORT MEADE	4	0	0	N/A	NO	5	22	FORT MEADE
IOWA CITY	17	1.6	31.4	12 WEEKS	NO	5	22	IOWA CITY
DES MOINES	11	1.2	27%	24 WEEKS	NO	5	22	DES MOINES
GRAND ISLAND	4	1	33%	65 WEEKS	NO	5	22	GRAND ISLAND
KNOXVILLE	2	0	0	NA	NO	5	22	KNOXVILLE
OMAHA						5.	22	OMAHA
LINCOLN	6	0	0	0	NO	5	22	LINCOLN
HOT SPRINGS	8	0.8	25%	19 WEEKS	NO	5	22	HOT SPRINGS
FORT LYON	4	1.2	25%	52+ WEEKS	NO	5	23	FORT LYON
SALT LAKE	13.5	1	37%	16 WEEKS	PENDING	5	23	SALT LAKE
SHERIDAN						5	23	SHERIDAN
FORT HARRISON	8	0.8	25%	29 WEEKS	NO	5	23	FORT HARRISON
DENVER	26	0.2	19%	2.8 WEEKS	YES	5	23	DENVER
CHEYENE	4.8	0	20%	12 WEEKS	NO	5	23	CHEYENE
GRAND JUNCTION						5	23	GRAND JUNCTION
MILES CITY	4	0.09	25%	5 WEEKS	NO	5	23	MILES CITY
LOS ANGELES OPC	6	0	0	N/A	YES	6	25	LOS ANGELES OPC
LONG BEACH	58	1.2	25%	4 WEEKS	YES	6	25	LONG BEACH
LOMA LINDA	14	1.6	50%	17 WEEKS	YES	6	25	LOMA LINDA
LOS ANGELES	76.5	9	34%	52+ WEEKS	YES	6	25	LOS ANGELES
LAS VEGAS	5.6	0.03	17%	8 WEEKS	REFUSED	6	25	LAS VEGAS
SAN DIEGO	33	14	42.4%	12 WEEKS	YES	6	25	SAN DIEGO
SEPULVEDA	33	1.4	9%	37 WEEKS	YES	6	25	SEPULVEDA
HONOLULU						6	26	HONOLULU
LIVERMORE	5	0	0	N/A	PENDING	6	26	LIVERMORE
FRESNO	11	2	19%	25 WEEKS	YES	6	26	FRESNO
MARTINEZ	27.7	1	11%	3 WEEKS	YES	6	26	MARTINEZ
RENO	12	2	50%	12 WEEKS	PENDING	6	26	RENO
PALO ALTO	26	0.9	36%	24 WEEKS	YES	6	26	PALO ALTO
SAN FRANCISCO	33	8	20%	26 WEEKS	YES	6	26	SAN FRANCISCO
PORTLAND	30	3	37%	14 WEEKS	PENDING	6	27	PORTLAND
BOISE	10	0.3	10%	4+ WEEKS	NO	6	27	BOISE
WHITE CITY	4	0.2	25%	6 WEEKS	NO	6	27	WHITE CITY
AM. LAKE/TACOMA	10	0.4	30%	15 WEEKS	PENDING	6	27	AM. LAKE/TACOMA
ANCHORAGE						6	27	ANCHORAGE
ROSEBURG						6	27	ROSEBURG
SEATTLE	35	13	32%	10 WEEKS	YES	6	27	SEATTLE
WALLA WALLA	4	0	0	0	NO	6	27	WALLA WALLA
SPOKANE	8.5	1.3	33%	7 WEEKS	YES	6	27	SPOKANE
NEW ORLEANS	40	6	9%	12 WEEKS	REFUSED	7	19	NEW ORLEANS
SHREVEPORT	23	0.85	36.8%	13 WEEKS	PENDING	7	19	SHREVEPORT
FAYETTEVILLE AR	9	1	8%	14 WEEKS	NO	7	19	FAYETTEVILLE AR
LITTLE ROCK	43	1.5	18.6%	9.3 WEEKS	REFUSED	7	19	LITTLE ROCK
MUSKOGEE	17	6	10%	17 WEEKS	YES	7	19	MUSKOGEE
ALEXANDRIA	11				PENDING	7	19	ALEXANDRIA
OKLAHOMA CITY						7	19	OKLAHOMA CITY
WACO						7	20	WACO

TEMPLE	23	2.5	10.5	25 WEEKS	YES	7	20	TEMPLE
DALLAS	35	5.1	10%	35 WEEKS	YES	7	20	DALLAS
MARLIN						7	20	MARLIN
HOUSTON	45	4	20%	12 WEEKS	NO	7	20	HOUSTON
SAN ANTONIO	30	1.6	20%	19 WEEKS	NO	7	20	SAN ANTONIO
BONHAM	3	0	0	N/A	NO	7	20	BONHAM
KERRVILLE	4	0.3	N/A	6 WEEKS	NO	7	20	KERRVILLE
TUCSON	19	2	25%	24 WEEKS	REFUSED	7	24	TUCSON
PHOENIX	17	1	17.6	8 WEEKS	PENDING	7	24	PHOENIX
PRESCOTT	10	5	55%	22 WEEKS	NO	7	24	PRESCOTT
EL PASO	5	0	0	N/A	NO	7	24	EL PASO
BIG SPRING	5	2	20%	104 WEEKS	YES	7	24	BIG SPRING
ALBUQUERQUE	20.5	4	50%	16 WEEKS	NO	7	24	ALBUQUERQUE

RECOMMENDATIONS FOR RESOLUTION OF THE
RECRUITMENT AND RETENTION PROBLEM
OF PHARMACISTS IN THE
VETERANS ADMINISTRATION
HEALTH CARE SYSTEM

1. Improve the overall salary and benefit package offered to be competative with that offered to pharmacists in both the retail and private hospital area. This salary structure must include the Chief Pharmacists, Assistant Chief Pharmacists, and Pharmacy Supervisors.

2. Reduce administrative impediments in the hiring process. Improve and streamline the application forms and the application procedure. Priority consideration should be given to update pharmacist classification standards and to consider converting pharmacists from Title 5 to Title 38, or a modified version of Title 38.

3. Improve the image of the Veterans Administration Hospitals and the Federal Health Care System. A strong public relations and advertising program should be considered to publicize the VA, its mission, its goals, etc. There is a need to attract professionals in several areas as well as pharmacy. Few people are aware of the VA and what actually occurs in the hospitals. This program should be in concert with recruitment drives at universities and major professional meetings held throughout the year.

4. Priority implementation of pharmacy programs. Consideration must be given to implement advanced support programs which provide a high quality of pharmacy service, support the cost containment goals of the Agency, and help to attract the most qualified professionals. Such programs include, but are not limited to unit-dose drug distribution systems, clean and attractive working conditions, increased clinical involvement of pharmacists, and current automated data processing systems. Such programs represent "**State of the Art**" and encourage recruitment and retention of highly qualified personnel.

5. Expand the role of technicians. An expanded performance requirement for pharmacy technicians should be considered. This will free pharmacists from routine, repetive, and technical tasks and allow them to take a more active role as a member of the health care team.

6. Support of the VA Pharmacy Management Trainee Program. The VA is in need of good managers and an executive development program. VA Central Office should be more aware of the Pharmacy Management Training Program and should provide centralized assistance to guarantee placement for

successful graduates. Additionally, at least one meeting of all trainees, preceptors, and the Pharmacy Central Office Staff should be funded annually.

7. Continuing Education Benefits
Central Office and Regional support should be provided to ensure that all pharmacists in the VA attend continuing education programs and keep abreast of changes within the profession. Authorized absence for such programs should be provided as well as reasonable tuition and travel support. Included in this benefit should be an annual meeting of all Chiefs of Pharmacy with Central Office Pharmacy Staff. It would be preferable to hold this meeting during the Midyear Clinical Meeting of the American Society of Hospital Pharmacists.

8. Increase stipends of VA Pharmacy Residents to be comparable with those of private sector residents.

9. Expansion of VA Health Scholarship Program
This program should be expanded to include pharmacists preparing for the Doctor of Pharmacy (Pharm. D.) Degree. Funding support can be offered with the requirement that the graduate work for the Veterans Administration for a period of time after receiving his/her degree.

10. Student Loans
Provide increased financial aid for students entering or considering entrance into a college of pharmacy. The obligation to repay the loan could be reduced or forgiven if the graduate was then hired by the VA, especially in a hard to recruit geographical location.

Statement of the

American Optometric Association

On

Recruitment and Retention of

Veterans Administration Optometrists

Submitted to the

SUBCOMMITTEE ON

HOSPITALS AND HEALTH CARE

of the

COMMITTEE ON

VETERANS' AFFAIRS

UNITED STATES

HOUSE OF REPRESENTATIVES

22
April 15, 1987

INTRODUCTION

The American Optometric Association is a professional society representing some 25,000 doctors of optometry, optometry residents, optometry students and educators across the nation. As an organization devoted to improving the vision care and health of the public, the American Optometric Association promotes the art and science of optometry wherever it is practiced.

A Doctor of Optometry is a health care professional who is specifically educated and licensed in each state to examine, diagnose and treat conditions of the vision system. Optometrists examine the eyes and related structures to determine the presence of vision problems, eye disease and other abnormalities. Through advanced technology and clinical training, optometrists may detect diabetes, hypertension, arteriosclerosis and other diseases of the body as well as primary ocular conditions such as glaucoma and cataract, which require referral to other health care practitioners for treatment.

I.

VETERANS' ADMINISTRATION AND VETERANS' NEEDS RE: OPTOMETRIC SERVICES

With the signing of Public Law 94-581 (1976), the enabling legislation which created the VA's Optometric Service, the Veterans Administration commenced recruiting qualified doctors of optometry to begin to meet the significant demand for eye care of the veteran population. Prior to the 1976 legislation the Congress reported that two-thirds of all screened veterans required eye care, yet fewer than one in ten eligible veterans received this needed eye care because there were virtually no VA staff optometrists or teaching affiliation programs. PL 94-581 enabled the VA to recruit 100 optometrists (as a start), created educational opportunities for optometry interns and residents and offered more competitive salaries (via the Title 38 pay system). These improvements were judged necessary by the Congress to modernize the VA's outdated practice of using only eye surgeons to provide surgical and nonsurgical care as well as primary eye care. The VA had been unique in its failure to use optometry staff, since the military and PHS hospitals as well as private HMOs and other groups generally employed two to three staff optometrists for each eye surgeon (ophthalmologist). Among the general civilian practices, there are twice as many optometrists (approximately 25,000) as ophthalmologists (approximately 13,000).

Prior to PL 94-581 the VA had only eight staff optometrists and one teaching program. Unlike all other federal hospital systems, the VA was forced to use eye surgeons to render not only eye surgery but also all levels of eye care, down to routine non-emergency screenings. This was noted by Congress to be a poor use of manpower and not cost-effective since there was only about one optometrist for every twenty ophthalmology staff and resident, a ratio far out of agreement with any rational distribution of medical specialties, forcing the VA to either provide primary and basic eye care so that VA surgeons would be free to perform their specialty or, inappropriately, reducing their ability to provide surgical care in an effort to provide general and primary care. This was not cost-effective since studies indicate well over half of all veterans seeking eye care can be fully cared for by optometry staff. Further, this more rational profile would also enhance ophthalmology care and ophthalmology training programs. This could result since, with optometry providing primary care and referral for surgery, ophthalmologists would have more time to practice their specialty and have more surgical referrals to them thereby making the best use of this scarce medical resource. In other words, the Congress announced to the VA in 1976 that the agency was out of date with all other federal and civilian providers of comprehensive eye care by relying solely on eye surgeons rather than a team of specialists, so that each specialty is appropriately employed. It simply didn't make sense to the Congress that the VA should be forced to use eye surgeons or eye surgeons in training to take time from providing their special care to also provide primary and general eye care

which could be provided at less expense by optometry staff. These management and cost concerns were further elaborated by the Government Accounting Office when it studied the VA's implementation of PL 94-581 (Study, The Role and Use of Optometry in the Veterans Administration Needs Improvement, GAO, June 21, 1978). The GAO also cited the inappropriate use of eye care manpower by the VA as well as the general failure to implement PL 94-581. The GAO called for the employment of at least 200 full-time optometrists and the creation of significant numbers of optometry teaching affiliations as well as the strengthening of the Service Director's office in VACO. The GAO also noted that in all other systems rendering eye care there were more optometrists than eye surgeons, yet the VA continued to be unique in having a reverse staffing ratio.

In its reply to the GAO study, the VA acknowledged the optometry staffing shortage and stated that it was hiring, as a first step, 30 full-time optometrists and would, over a multi-year period, hire the 100 additional staff called for by the Congress, producing a total force of some 100 full-time optometrists. The VA also stated to the GAO that this was a first step, and it agreed with GAO that approximately 200 full-time optometrists were needed in all. The VA also agreed that it had not yet created significant numbers of teaching affiliations and these would also be implemented.

Further evidence of the optometry staff shortfall was shown by an estimate prepared by the Director, Optometric Service in 1980 that 296 full-time staff were needed. The Director also cited the 1980 HHS health manpower requirements that, when applied to the VA's staffing and veteran population, it classified veterans as being in an "underserved" category. Using HHS methodology, 132 full-time optometrists would be needed to marginally bring the VA population out of the category of "underserved". This HHS formula took into account both ophthalmology and optometry staff. As a result of these and other portrayals, the VA Chief Medical Director, in 1980, publically acknowledged a minimum of 120 full-time optometrists were needed.

Again in 1982, the Congress queried the VA as to where it stood in modernizing its eye care by securing appropriate numbers of staff optometrists. First initiated by a letter from Senator Thurmond for detailed information on the development of the optometry program, this request was broadened in scope by Congressman Montgomery to include not only all eye clinics but both optometry and ophthalmology manpower, their working relations, the impact upon eye care (quantity and quality) by optometrists, and the opinions of the hospital chiefs of staff on the effects produced by the use of optometry staff. This inquiry by Senator Thurmond and then by Congressman Montgomery was first triggered by a concern that the VA had still, some seven years since the passage of PL 94-581, only added about 55 of the 100 optometrists intended by Congress via PL 94-581.

The VA conducted a survey in order to answer the congressional inquiries. This 1980 survey, conducted and jointly prepared by the VA's Surgical Service and Optometric Service, was endorsed by the VA's Department of Medicine and Surgery and transmitted to Congress in April, 1983 as the agency's response to the issues raised by the congressional inquiries.

The survey reported data from 168 of the 172 VA medical centers and remains today, even four years after its release, the most comprehensive and exhaustive study to date. The study reported deficiencies and positive aspects of VA eye care; some of these are encapsulated below:

Deficiencies Cited By The Study

* "The bulk of clinical staff is provided by ophthalmologists and residents in ophthalmology. Total ophthalmology staff is 372.2 FTEE (includes 235 residents) as compared to a total optometry staff of 92.3 FTEE (includes 26 residents). There are 0.25 optometry FTEE for every 1.0 ophthalmology FTEE. This ratio is low and is compared with other general health care systems (HMO, DOD, civilian) in Figure 3 where the range is from 2.5 to .9 optometry FTEE per ophthalmology FTEE." (Survey, Introduction, pg. 2).

* Average waiting time for eye appointments was 38 days, with 84 centers in excess of 30 days and 75 centers having restricted acceptance of eye clinic appointments. (The ACMD for Professional Affairs determined any delay over 30 days to be unacceptable.) In fact, 41 medical centers had delays in excess of 60 days.

* Twenty-eight stations had no eye clinic staff and 99 stations reported less than 0.1 FTEE optometry staff (less than 4 hours of optometry staff coverage per week).

* There were 65 medical centers with ophthalmology teaching programs and only 41 with optometry teaching affiliations, with 235 ophthalmology residents being trained while only 26 optometry residents were in training.

Postive Study Findings

Seventy-three medical centers reported having both optometry and

ophthalmology staff and at these 73 stations which had initiated team eye delivery as envisioned by Congress via PL 94-581, their chiefs of staff reported that:

* At 56 centers, the chiefs of staff reported the professional cooperation between optometry and ophthalmology to be "excellent"; 15 reported "good" relationships; 2 reported "acceptable" and not one responded in the two remaining categories of "fair" or "poor".

* "All 73 (chiefs of staff) reported their optometry sections had increased the type, scope and quality of their station's eye/vision care." (Survey, Summary of Findings, pg 1).

* All 73 chiefs of staff reported that timely and appropriate referrals were being made by optometrists to ophthalmologists.

The VA report made a detailed station by station analysis of patient workload and staffing profile, waiting time for eye appointments and requests for resources. After careful review the report stated that "Based upon a review of each VAMC's response, its eye/vision needs, staff levels, affiliations, waiting times, and Rx activities, it was determined

that 66 VAMC's needed increased optometry staff coverage and 26 needed increased ophthalmology staff coverage. These equate to 46 FTEE additional optometry staff and 9 FTEE additional ophthalmology staff."

Thus the 1983 Survey again confirmed that while the VA made some effort to implement a more rational cost-effective eye care delivery system, it had fallen far short. For example, the total full-time optometry staff in 1983 was 67 (70 as of 1987), far short of the 108 that would have resulted from adding the 100 called for by the Congress in 1976. Even the current 1987 figure of 70 full-time also falls far short of the 120 called for by the Chief Medical Director in 1980, the 132 required to meet the HHS criteria and the 200 agreed to by the VA in response to the GAO in 1976.

Additional Evidence Showing Cost-Effectiveness of the VA Optometry Staff

In addition to the above well-documented need for and desirability of optometry staff, further evidence has recently been revealed following the VA's adoption of DRG reimbursement methods in its Resource Allocation Methodology (RAM). The key feature of VA eye care delivery critized by all past studies has been the VA's inability to better tailor its eye care staffing to its patient care needs by primarily having only eye surgeons and their residents available. Thus, the VA was providing entry level, primary care as well as secondary and tertiary care using these tertiary care providers. As previously noted, such a staffing profile is

not used by any other similar federal provider. This use of tertiary care providers resulted in a comparitively high cost-per-treatment episode since expensive and scarce eye surgeons had to be "all things to all people" under the antiquated VA system.

Even though the VA has fallen short of adding appropriate numbers of optometrists, there now exists a statistically significant number of jointly staffed team eye clinics with optometry and ophthalmology staff, residents and students. And for the first time within the VA, the RAM system has tracked the cost-to-benefit ratios of different patient care services within each hospital. These RAM-generated data support the opinion of Congress that greater use of optometry staff is cost-effective; the marginal cost-per-treatment episode has decreased dramatically with the introduction of optometry staff. That is, adding optometry staff to produce a more rational staffing profile greatly expands the number of patients who can be treated, reduces patient backlogs and greatly lowers the cost-per-patient treatment episode. Additionally, under the RAM cost accounting system, these team eye care clinics have become what is commonly referred to as "DRG winners", generating resources for their VA hospital via the RAM methodology, far in excess of operating costs. The VA has documented what many other eye care provider models have maintained for years: Optimum and least-costly eye care results when using a staff of optometrists and ophthalmologists in proportion to the need for their services.

To conclude this portion, all evidence to date indicates Congress was correct in creating an Optometric Service and calling for optometry staff and training programs as a means to improve VA patient care and lower cost-per-treatment episode. This is more important today than in 1976 due to the constantly shrinking federal dollar. However, the VA is unable or unwilling, even in the face of a preponderence of evidence from both outside and within the agency, to approach minimal staffing levels that it has publically acknowledged should be met. In view of severe budgetary problems facing the VA where each federal dollar must provide the maximum in cost effective patient care coupled with a rapidly aging veteran population and its attendant increased eye care problems, the VA must now act to make the best use of its resources. With the ever-increasing numbers of eye care problems needing treatment in this expanding veteran population, the VA can ill afford to defer meeting its self-acknowledged staffing needs; to do so would be both fiscally and medically inappropriate.

II.

THE EXISTING OPTOMETRY PROGRAM AT RISK

The above section dealt with the VA's failure to adequately recruit optometrists and develop the optometry program. This section addresses matters which are weakening the present optometry program so that, even in the face of proven excellent results, the VA is in danger of failing to preserving it. At the heart of this are the issues of recruitment and retention.

Non-Competitive VA Optometry Salaries

In 1976, PL 94-581 cited poor salaries as a central factor inhibiting the hiring of staff optometrists. By moving VA optometrists to the Title 38 pay structure, salaries were created which began to approach those in the private sector. While falling short of 1976 private practice incomes, these VA salaries were sufficiently competitive that high quality optometrists interested in hospital-based practice, as well as teaching affiliations, were successfully recruited. These individuals are now the senior clinic chiefs within the VA system and have developed both patient care, teaching and research programs, as a testiment to the quality of staff initially recruited. Unfortunately the VA optometrists' salaries have not kept with the increasing private sector, particularly at mid and advanced career levels. The result is that increasing numbers of senior

VA optometrists are leaving the system. These experienced VA clinicians are accepting leadership positions in other health care centers and teaching institutions. The salary gap is significant. The most recent data available show average full-time optometrists' salaries to be about $45,614 while the average privately practicing optometrists has a net income of about $62,673. This means the average VA salary is 36% below the average for the private sector. This salary gap is more critical because the VA optometrists are widely recognized to be of particularily high caliber in professional ability while having increased patient care responsibilities, due to training and the demands of a medical center environment.

The salary gap problem cascades down to the VA residency program as well, since all of these training programs are directed by these key senior optometry staff; with the absence of training program directors, the optometry residency program suffers.

In addition to the increasing retention problems, the VA, if it chose to recruit optometrists to complete the long-defered development of the optometry program, would face a serious recruitment problem. (Since the VA has failed to recruit the optometrists it said it needs, to meet the congressional timetable, few positions are available and consequently recruitment is not even attempted.)

The effect of the salary gap is further compounded by the development of additional opportunities for practice in a medical environment, similar to the VA, so that the VA has lost some of its recruiting potential. The attributes of a team approach to eye care, emphasizing cost effectiveness as espoused by Congress in 1976, is to be seen in the private sector. In the past five years, there has been a rapid development of "co-management centers" whose key feature is team delivery care by optometrists and ophthalmologists. These centers now offer a medical environment attractive to recent optometry graduates and in the past few years, many VA residents have been recruited to them following their VA training. In fact, many of these centers (and schools of optometry) require residency training (of which the VA provides the bulk) for appointment to the co-management center group. These attractive modes of practice, coupled with the expanding salary gap, have left the VA unable, in the main, to recruit its own residents, even though a prime reason for such residency programs is to recruit VA staff. Also, the co-management centers have recruited half of their clinic directors from the ranks of the senior VA optometrists. The problem can be distilled to the fact the VA, having established a standard of excellence for its staff training program, has allowed salaries to fall behind to such a degree that both its residents and senior staff are now rapidly being recruited away with the consequence that the investment the VA made in these programs is beginning to evaporate. It seems clear that another adjustment in salaries must be accomplished because the slippage since 1976 has produced salaries which are now about 36% below the average for private

incomes. This salary adjustment is even more critical since the VA optometrists have exceptional demands made of them in their work environment. While we understand and appreciate the VA cannot be expected to fully match salaries offered by models and opportunities outside the VA, it should be expected that the agency could provide some monetary inducement as a signal that VA optometrists represent a highly valued resource. Such an indicator, when coupled with the admittedly professionally stimulating environment would allow the agency to retain these exceptional practitioners. But the VA cannot hope to retain these individuals with average salaries 36% below private practice. And the VA cannot hope to retain faculty caliber senior staff with salaries 36% below average salaries. Finally, while the VA has admitted its optometry program is small (smaller than is required or anticipated by Congress), has correctly prided itself on its quality of service. That quality is now showing the cracks of erosion and without some salary augmentation, the program is destined to erode to an unacceptable level. This erosion will spread and not only damage patient care but teaching affiliations as well since the two are interrelated.

To conclude this portion, the VA Optometric Service and its teaching affiliations are of the highest quality. All available evidence prove the wisdom of Congress when, in 1976, it instructed the VA to modernize its eye care by building an Optometric Service. Increased numbers of patients are now being given higher quality and more comprehensive eye care at less cost-per-patient treated. Better use is being made of

scarce eye surgeons, and reports from chiefs of staff unanimously agree that team delivery by optometrists and ophthalmologists is a quantum improvement; the VA's DRG system indicates increased productivity has resulted as well.

Unfortunately, in the face of ten years of consistent positive data, congressional urging and even its own studies, the VA has not honored its pledge to build its optometry program to even the lowest level recommended. That level was 108; the VA now employs 70 full-time optometrists. Since 1983 when the VA's own study cited an immediate need for 46 optometrists, it added just 6. This performance, viewed against a backdrop of the ever-increasing requirement to be more cost-effective and reduce cost-per-patient treated, falls short of adequate.

Finally, the VA is not acting to preserve the small but excellent program it has created. The salary gap can no longer be ignored. The VA must, through a program such as outlined below, begin to ameliorate this situation before the quality is damaged and the cost-per-patient is increased. In III, Recommendations, are what we offer as minimal steps to correct this problem. These measures are modest and require only small incremental costs. This program would only reduce the existing salary gap from 36% to about 30%, but it would provide important awards, not in a wholly monetary sense, but for recognition of important program responsibilites.

III.

RECOMMENDATIONS

VA Optometry Staff

Depending upon the particular VA statement cited in the last six years, the minimal numbers of optometry staff range from about 110 to 120, with the GAO, AOA and other estimates upwards of 500. The AOA proposes the VA finally honor its long-standing commitment by meeting a staffing floor of about 110 optometrists. This would require the addition of 40 optometrists, which is close to the number cited in the VA's 1983 study. The AOA proposes this be accomplished over a three year period. By any standard this seems a fair request and one which would produce a staff level that Congress intended to be reached by 1981. Fiscal wisdom, evidenced by the VA's resource methodology, supports this position as the VA can no longer afford to misuse its medical specialists i.e., using eye surgeons to render optometric care.

Salary Gap

In addition to failing to meet congressional and agency commitments on staff additions, the VA is now losing key senior clinicians to competing health care provider organizations. Because of this salary gap and the acknowledged quality of VA optometric services, the VA has now become a

prime recruitment resource for these organizations. Therefore, some salary relief should be accorded these clinicians, just as salary relief has been given to other VA health care professions, due to the non-competitive nature of federal salaries for select health care disciplines. The cost for the proposed program is minimal, yet failure to provide this salary relief will accelerate the loss of experienced VA clinicians as well as teaching affiliations.

The American Optometric Association recommends that Congress ammend 38 USC 4118 to include optometrists. This salary augmentation should be limited to full-time staff. It should not be prorated for part-time staff who should receive no salary augmentation.

Salary enhancement should be distributed primarily to retain senior key staff; those individuals who have been, and continue to be recruited away from the VA.

* Full-time clinicians in grades Associate, Full and Intermediate with less than 6 years continuous service...$3,000 per annum.

* Full-time clinicians with more than 6 years continuous service holding grades Senior or Chief...$4,000 per annum.

* Full-time clinicians serving as the administrative chief of an optometry section, service or equivalent clinic...$2,000 per annum.
* Full-time clinicians serving as directors of a facility optometry training program for residents and/or interns...$2,000 per annum.

The estimated cost is under $500,000 representing less than 6% of the present optometry salary cost and will only reduce the salary gap of 36% to approximately 30% but will provide some recognition for additional program responsibilities.

We thank the Committee for the opportunity to offer our views and present the case for the VA's optometry program. We hope this testimony will assist the Committee in its deliberations on recruitment and retention problems of VA doctors of optometry.

DD/lb

apta American Physical Therapy Association

MAY 1 1987

April 29, 1987

The Honorable G.V. Montgomery
Chairman, Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Mr. Chairman:

The American Physical Therapy Association (APTA) appreciates this opportunity to submit a statement for the record of the hearing held by the Subcommittee on Hospitals and Health Care on April 22, 1987. We are especially concerned with the issue of recruitment and retention of health care professionals, one focus of the hearing.

Surveys which have been completed by the APTA over the last several years in attempt to monitor the effectiveness of Title 2 of Public Law 98-160 have routinely shown that physical therapist staff levels within the Veterans' Administration Medical Centers (VAMCs) are inadequate. We have provided these surveys to the Subcommittee as they were compiled.

Also, the Subcommittee now has the benefit of the latest Veterans' Administration survey conducted in December 1986. That survey looked at 16 occupations and found that the turnover rate for physical therapists is 25.9% and the vacancy rate is 22.9%, levels higher in both categories than for any of the other occupations surveyed.

The question no longer is the extent of the staffing problem, but how it can be solved. Certainly, one approach would be through implementation of special rates. This authority for this approach already rests with the VA. There is one particular problem, however, which has rendered these rates an ineffective remedy.

All of the VAMC's are experiencing financial pressures, and are not in any condition to request the authority to spend money that will have to come out of their already tightly stretched budgets. Since special rates do have to come out of their own budgets, few VAMCs are requesting them.

The APTA suggests an alternative approach to the problem, and this approach relates back to Public Law 98-160. That law was meant to solve the problems of recruitment, retention and morale of physical therapists and others within the VA. It has not had the desired effect, and a major reason for this shortcoming is that a portion of it has yet to be implemented.

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Public Law 98-160 provided for the review of physical therapists' qualifications and special achievements and for consequent increases in salary where warranted. This process is still underway. Yet, there are certain therapists who may never receive recognition of their qualifications and special achievements. This is because the VA has taken the position that physical therapists in Grade 9 and above cannot be advanced above their grade despite the presence of any of the criteria that have been identified in the VA Circular 00-85-9. As a result there are a number of physical therapists who are essentially being told that, although they have achieved their current level because they are valuable employees, if they want any further advancement they should start looking outside the VA.

We suggest that this situation be remedied by the following steps. First, in order to place the VAMCs on a more competitive basis with the private sector, the journeyman level for physical therapists be raised from a GS-9 to a GS-10. This would mean starting newly hired physical therapists at a GS-9 as is currently the case with pharmacists.

Under this new system, physical therapists would be advanced to a GS-10 after one year. Then, after two years at the GS-10 level, the individual physical therapist would be reviewed for the development of specialization. If specialty areas had been developed in such areas as geriatrics, orthopaedics, etc., then that therapist should be advanced to a GS-11. Physical therapists who have not developed specialty areas would remain at GS-10, the newly established journeyman level.

In this same format, chiefs would also advance to a GS-12 if the staff has any GS-11s without reference to the number of therapists supervised. Currently, a chief cannot be a GS-12 unless he or she supervises fifteen physical therapists. This also means that, unless the chief is a GS-12, none of the staff therapists can be a GS-11 because a chief has to be one grade higher than staff therapists.

Upward mobility is the primary element that is lacking in the VA. And that is the long term advantage that the private sector has to offer. The system that we propose would go far to remedy this situation.

Finally, we greatly appreciate Congress' action last fall in enacting Public Law 99-576. A section of that law granted the VA the authority to hire part-time and temporary physical therapists under Title 38 authorities rather than under the less attractive Title 5 authorities to which it was limited before in those instances. We must say though that we have seen no movement on the part of the VA to implement this recently-granted authority. Prompt action on the part of the VA to do so would be of assistance in slowing the turnover for physical therapists.

We appreciate this opportunity to participate in the Subcommittee's deliberations and its development of approaches to ensure that quality care

is delivered to our veteran population. We will be happy to provide you with any further assistance that you might find helpful in these matters.

Sincerely,

R. Charles Harker

R. Charles Harker, Esq.
Director of Government Affairs

RCH/fm

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

Office of the
Administrator
of Veterans Affairs

Washington DC 20420

Veterans
Administration

JUN 19 1987

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans'
Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed please find the Agency's responses to the questions which you forwarded on behalf of Congressmen J. Roy Rowland, Daniel A. Mica and yourself for the April 22, 1987, hearing by the Subcommittee on Hospitals and Health Care. Thank you for the opportunity to provide this additional information for the record.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosure

CONGRESSMAN MONTGOMERY

Question: 1. Dr. Gronvall, you referred to a Department of Medicine and Surgery Task Force on Recruitment and Retention. When will that Task Force complete its job and provide you with a report?

Answer: The Task Force is meeting regularly and obtaining the input of professional leaders from our field hospitals, from their Services in VA Central Office, from the Veterans Service Organizations, as well as others. I have asked them to forward a report to me by July 10, 1987, but they are providing suggestions and recommendations on an ongoing basis as noted in my testimony.

Question: 2. Dr. Gronvall, in your opinion, how much more money should be allocated to the Health Professional Scholarship program to allow that program to maximize its benefit on recruitment and retention?

Answer: Considering all other resource requirements for FY 88, I believe our request for $6.0 million for this program is most appropriate.

Question: 3. Dr. Gronvall, have you considered a Distinguished Nurse position similar to the Distinguished Physician position in order to enhance nursing in the VA?

Answer: Currently, the Department has an active Task Force that is charged with studying recruitment and retention problems, and with identifying long-term solutions. The Task Force is considering a number of potential options, one of which is the Distinguished Nurse position.

Question: 4. Dr. Gronvall, the President of the Nurses Organization of the Veterans' Administration remarks in her written testimony that "on-call" pay for operating room nurses is below the private sector pay. Has the VA reviewed that situation and if so, are you planning any remedial action?

Answer: DM&S is not aware of extensive problems with respect to the competitiveness of "on-call" pay for operating room (OR) nurses. A problem was experienced by the VAMC, West Los Angeles, and an increase in the on-call rate to 35% of the hourly rate has been authorized for OR nurses at that facility. The appropriateness of the use to date of the current authority of the Administrator to adjust on-call rates in order to recruit and retain nurses is among the areas being considered by the Department's Staffing Shortages Task Force.

CONGRESSMAN ROWLAND

Question: Regarding the per diem payments paid by the VA to State Veterans Homes for veterans under their care, I understand that the per diem payment is lost if a patient leaves the Home for a period exceeding 96 hours. Once the veteran is gone for the 96 hour period, the per diem payments are canceled for that veteran. The payments are stopped from the time the veteran left the Home, not from the end of the 96 hour period.

State Homes are put in a difficult situation here. When a veteran vacates a bed, let's say for hospital care, the Home cannot simply fill that bed with another veteran. The Home must hold that bed open for the veterans return, which is not always a date certain. Therefore, the Home loses the per diem payment for the veteran that vacated the bed, but it must hold the bed open for that same veteran.

Could you comment on the per diem payments and the situation I have outlined?

Answer: VA Manual M-1, Part I, Chapter 3, Paragraph 3.31 defines absences from State homes. Per diem payments are continued for the first 96 hours that a veteran is absent from the State home unless the veteran is being treated in a VA medical center or in a community hospital at VA expense. In that case, per diem payments are discontinued when the veteran leaves the State home to receive hospital care. This policy was established to avoid making duplicative payments for care of the same veteran. In 1984, the National Association of State Veterans Homes inquired about this policy suggesting that it was costly to the States to keep the State home bed available for the veteran's return, but receive no per diem payment for it. VA investigated this matter and concluded that changing the policy would be far more beneficial to the States than to veterans, but if States could demonstrate what benefits the veterans might receive from such a change, and provide an estimate of the annual cost to the VA, then the VA would re-evaluate the policy to determine if it should be changed. The VA has never received such information from the National Association of State Veterans Homes and therefore has made no changes in the policy.

CONGRESSMAN MICA

Question: When enacted in 1976, Public Law 94-581 fully integrated Veterans Administration doctors of optometry into the Title 38 pay and personnel system in a fashion identical to physicians and dentists (see 38 USC 4101-4117). PL 94-581 also incorporated optometry residents into those portions of the Title 38 statute which apply to residents and interns (see 38 USC 4114).

Prior to the passage of PL 94-581, VA optometrists and residents were subject to the Title 5 civil service pay and personnel system. For over 10 years, VA optometrists have been a part of the Title 38 system but the VA optometry residents have yet to be transferred into the Title 38 system.

What progress has the VA made to transfer VA optometry residents into the Title 38 system?

Answer: VA optometrists were converted from Title 5 appointments to Title 38 appointments under provisions of P.L. 94-581, dated October 21, 1976. Optometry residents were first appointed in the VA in 1975. They were at that time and still are appointed under Title 38. However, because their residencies only last one year, they are not eligible for retirement and insurance benefits.

This is similar to the way other health trainees such as pharmacy interns and psychology trainees are treated.